Hospital Management

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Hospital accreditation plans
Factors controlling length of stay
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Psychiatric aides in mental hospital
ABC's of civil defense

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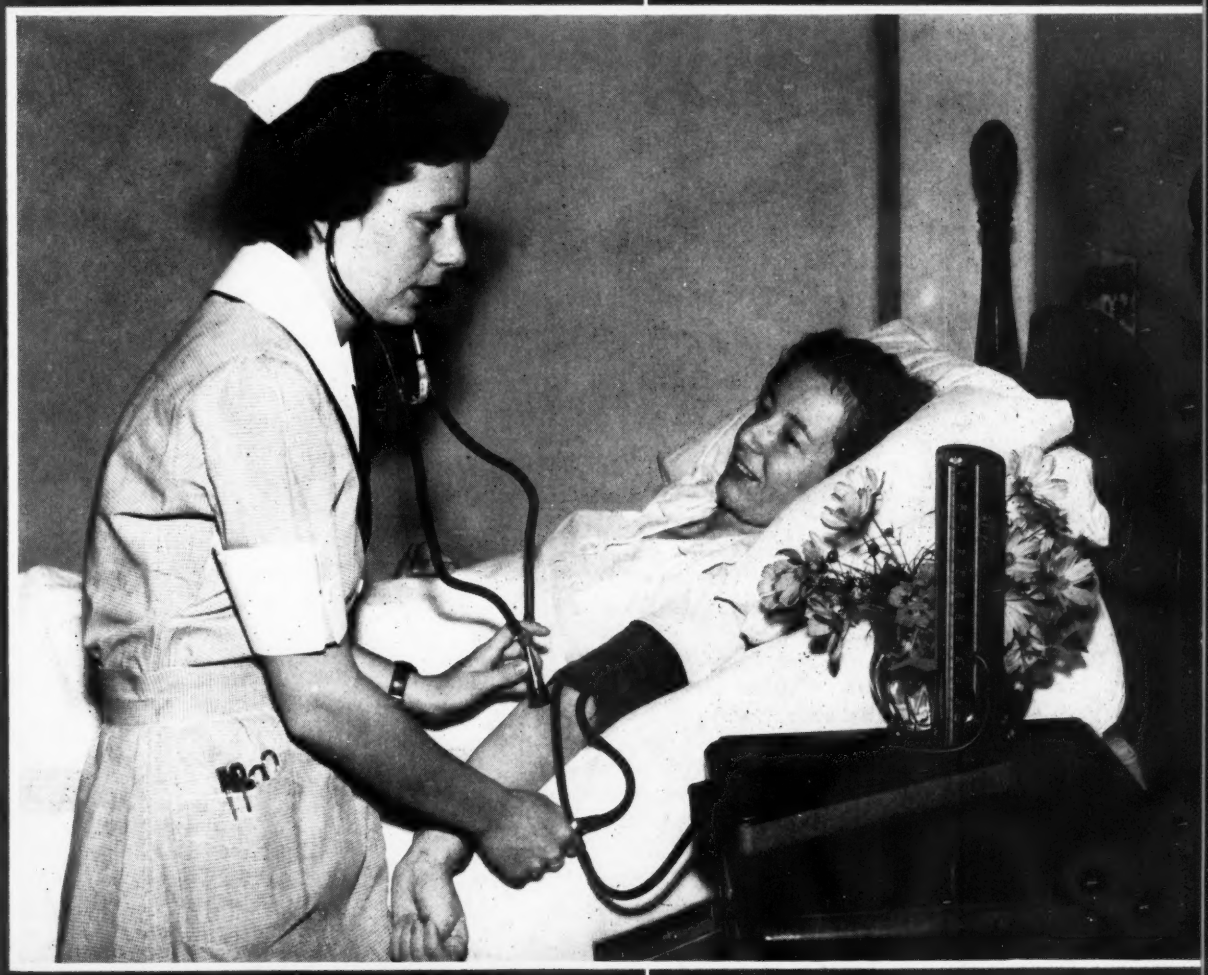
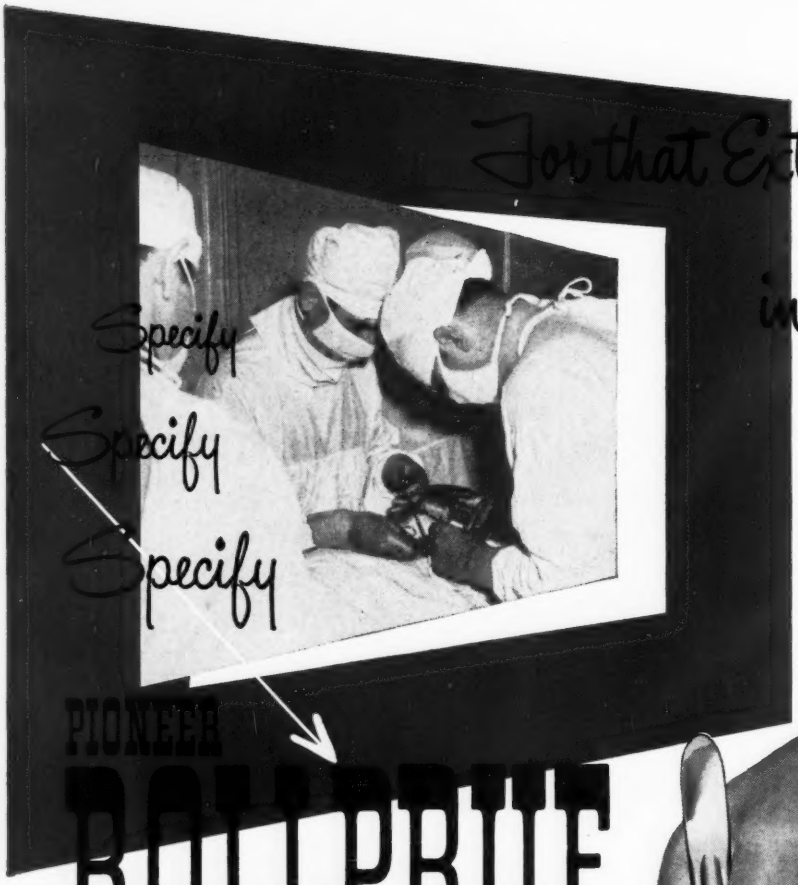
the news and technical journal of administration

February · 1952



See page 4

For that Extra Assurance in Surgery



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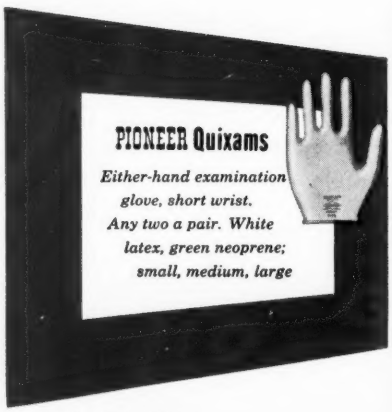

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as others see us

A new diagnostic service

■ ACCURATE diagnosis is the essence of good medical practice. Hospitals know it, for which reason laboratories staffed by well-trained men and women are under the same roof with beds and operating rooms. Indeed, without good laboratories the scientific practice of medicine is virtually impossible. Though physicians realize this they sometimes hesitate to send their patients to laboratories because of the expense involved. X-ray pictures may cost from $10 to $100, chemical analysis of body fluids from $5 to $50, a biopsy and a pathological report as much as $100, depending on its scope. Several hundred dollars may thus be expended in diagnosing a puzzling case. Hence the inauguration of a diagnostic service by the Fanny Markel Medical Group, a non-profit organization which is sponsored by the Madison Foundation for Biochemical Research and which has been approved by the Comitia Minora of the Medical Society of the County of New York.

For $75 the patient who is referred to the Group by his physician or consults it of his own accord receives all the diagnostic attention that his case needs. There are no "extras," not even for expensive x-rays or other special examinations of organs and tissues. A report goes to the patient's physician and to him alone. Thus armed, the physician knows exactly what therapeutic measures are to be taken. His patient saves time and money.

We have here an important experiment. Preventive medicine is preached by every conscientious physician. One reason why his insistence on periodic examinations and laboratory tests is not always heeded is the high cost of diagnosis. The Fanny Markel Medical Group seems to have indicated how the cost can be kept within bounds and the healing task of the physician simplified. ■

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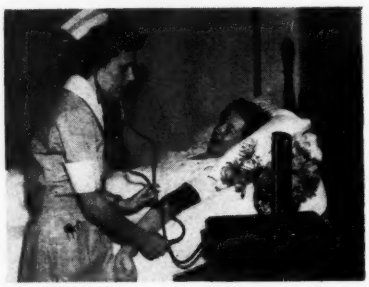
The cover picture

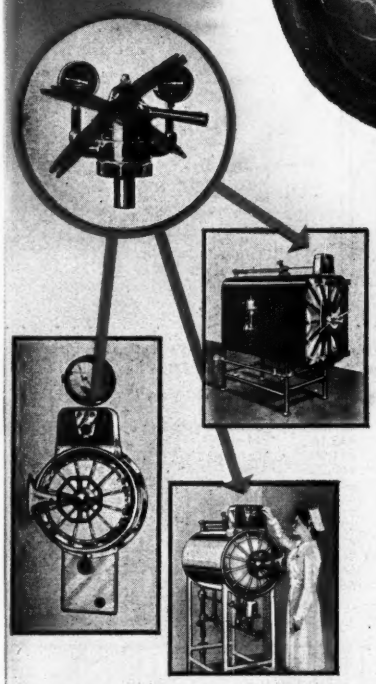


■ PRACTICAL NURSE STUDENTS learn to take blood pressure readings at Charles T. Miller Hospital, St. Paul, Minn.

This picture is regarded as somewhat of a milestone because it represents, in pictorial form, a point in the evolution of the practical nurse from a person who has done the more menial bedside tasks to something more professional.

This metamorphosis is an interesting reaction on the part of hospitals to the demand for more and more bedside care for more and more patients at a time when there are never enough graduate nurses to go around. ■

Precision-proofing IN A NUTSHELL



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new how's business department with the american association of hospital accountants

by **F. James Doyle**

Hospitals occasionally write or phone this department in some perplexity to find out why the figures for their particular institutions vary so much from the averages presented on these pages.

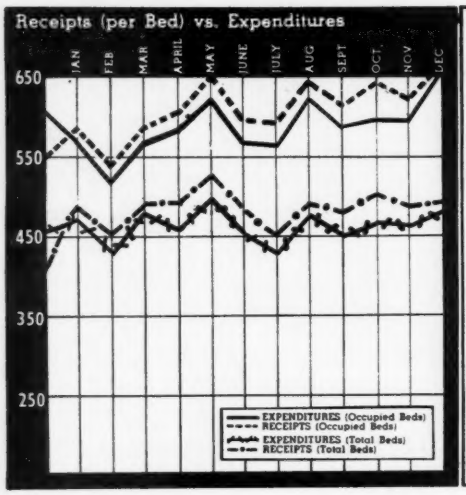
As an instance of the variations which may be observed in the returns we receive, compare a few figures from two hospitals of approximately the same size in the same geographic area.

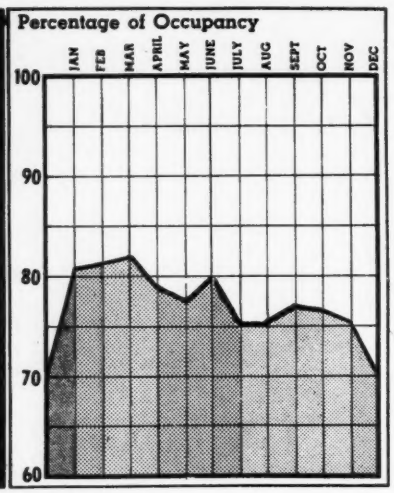
Obviously, if we average these two hospitals, we get figures fairly remote from the actual operation of either one. But the ordinary hospital of that size in that area may well be closer to their average than to either institution individually.

	222 beds	242 beds
Administration	$ 20,704	$ 6,224
Plant operation	16,425	5,823
Med. & Surgical	13,372	3,384
Total Operating Expense	147,788	92,983

Anyway the example of range quoted above shows clearly why your figures may differ considerably from ours, with no prejudice to either.

National Averages





Average Monthly Occupancy (on 100 per cent basis)

October, 1949	80.16
November, 1949	79.90
December, 1949	71.28
January, 1950	78.25
February, 1950	80.44
March, 1950	79.20
April, 1950	77.67
May, 1950	76.54
June, 1950	76.26
July, 1950	73.38
August, 1950	74.90
September, 1950	73.62
October, 1950	77.10
November, 1950	76.63
December, 1950	71.57
January, 1951	80.58
February, 1951	81.82
March, 1951	82.05
April, 1951	78.60
May, 1951	76.98
June, 1951	79.50
July, 1951	75.70
August, 1951	75.72
September, 1951	76.84
October, 1951	77.26
November, 1951	75.70
December, 1951	71.13

Av. Operating Expenditures Per Occupied Bed Per Month

November, 1950	578.46
December, 1950	610.44
January, 1951	568.78
February, 1951	520.72
March, 1951	564.51
April, 1951	580.44
May, 1951	623.84
June, 1951	568.14
July, 1951	566.22
August, 1951	623.94
September, 1951	584.22
October, 1951	593.68
November, 1951	597.14
December, 1951	668.52

Average Patient Charges Per Occupied Bed Per Month

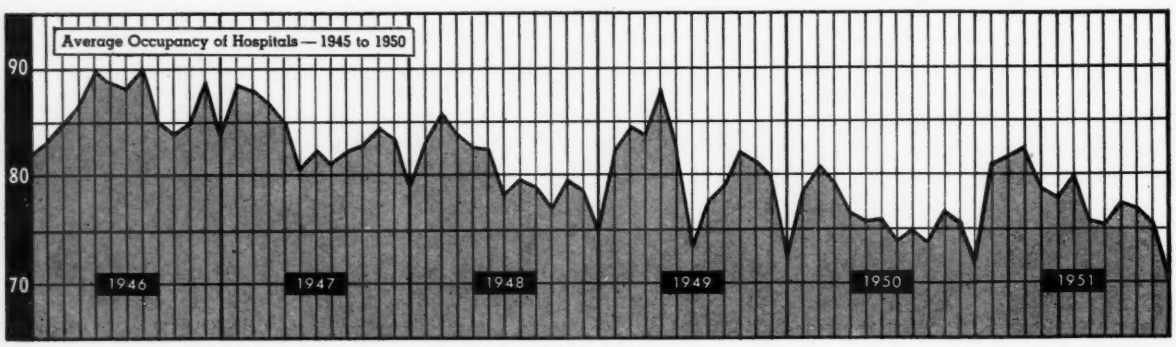
November, 1950	553.49
December, 1950	550.19
January, 1951	574.86
February, 1951	543.16
March, 1951	579.46
April, 1951	606.60
May, 1951	664.22
June, 1951	589.15
July, 1951	588.05
August, 1951	641.61
September, 1951	610.90
October, 1951	644.73
November, 1951	625.06
December, 1951	662.84

Av. Operating Expenditures Per Bed Per Month (Total Beds)

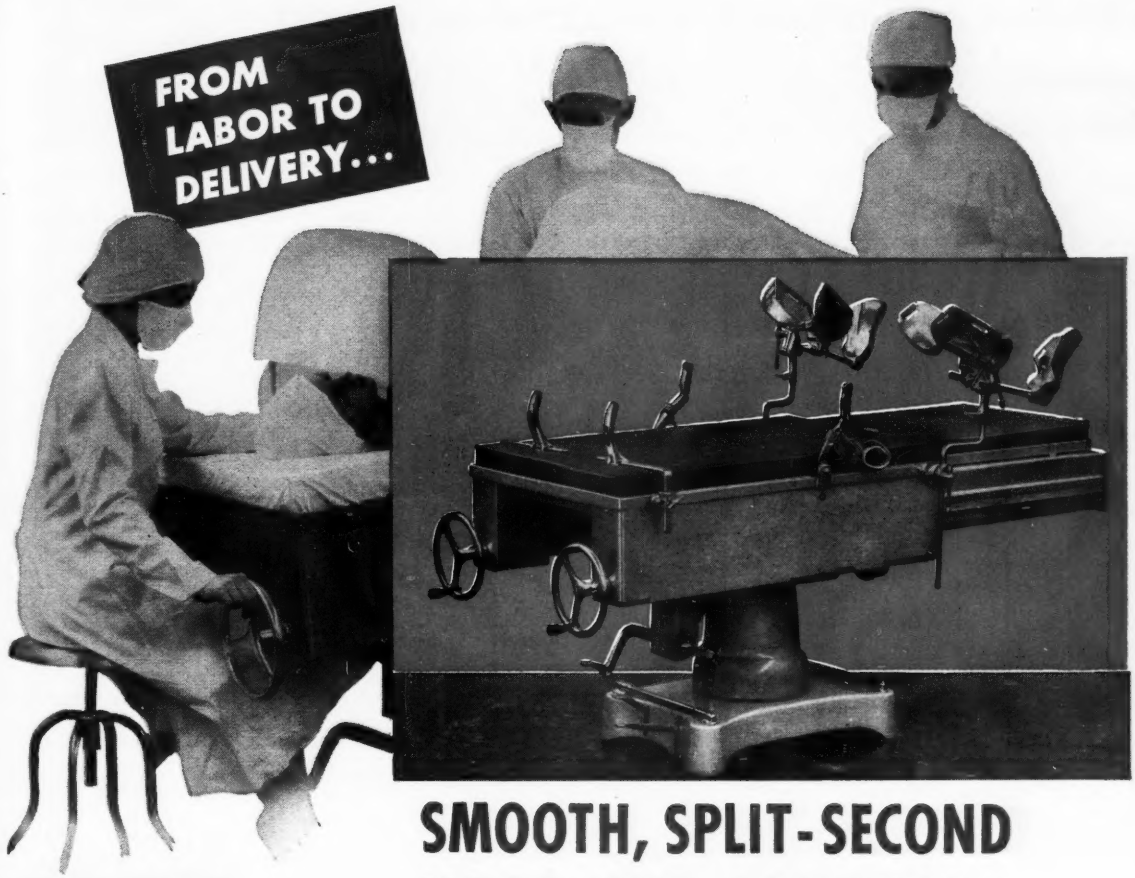
November, 1950	443.28
December, 1950	452.03
January, 1951	467.08
February, 1951	432.10
March, 1951	471.00
April, 1951	460.21
May, 1951	488.40
June, 1951	452.67
July, 1951	433.33
August, 1951	474.23
September, 1951	451.99
October, 1951	462.48
November, 1951	464.99
December, 1951	484.14

Average Patient Charges Per Bed Per Month (Total Beds)

November, 1950	424.15
December, 1950	405.18
January, 1951	472.07
February, 1951	450.90
March, 1951	483.47
April, 1951	488.87
May, 1951	520.01
June, 1951	469.41
July, 1951	450.03
August, 1951	487.66
September, 1951	472.62
October, 1951	502.26
November, 1951	486.73
December, 1951	479.44



FROM LABOR TO DELIVERY...



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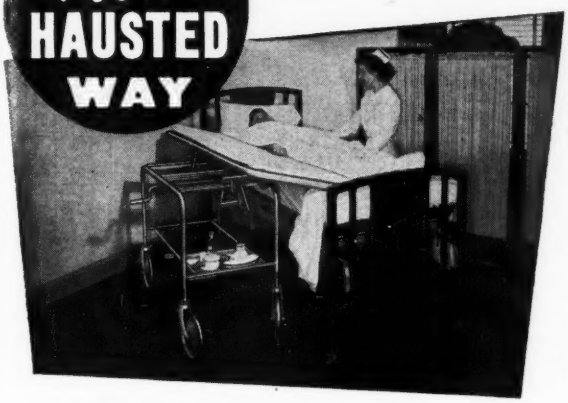
December 1951 regional how's business report

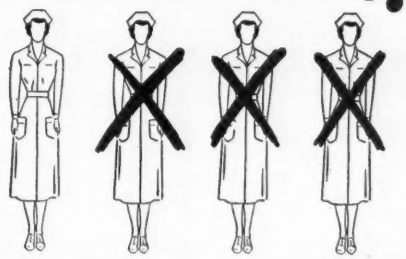
REGION →	NEW ENGLAND Connecticut, Maine, Mass., N. H., R. I., Vermont			MIDDLE ATLANTIC New Jersey, New York Pennsylvania			SOUTH ATLANTIC Del., Fla., Ga., Md., N. C., S. C., Va., W. Va., D. C.			SOUTH CENTRAL Ala., Ky., Miss., Tenn., Ark., La., Okla., Texas		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,089	2,180	11,560	1,356	3,496	6,729	1,398	2,688	8,815	1,509	3,371	10,060
% of OCCUPANCY	48.79%	58.10%	77.53%	62.67%	69.18%	79.50%	57.80%	61.94%	73.96%	85.38%	75.20%	75.82%
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$1.94	$3.13	$3.20	$1.48	$2.77	$1.90	$1.00	$1.60	$2.16	$1.62	$2.55	$2.22
Dietary	3.35	2.93	3.90	2.10	3.10	3.34	2.29	3.42	3.53	2.48	2.95	3.17
Housekeeping	1.16	1.17	1.31	.36	1.01	.99	1.11	.91	1.05	.87	1.00	.98
Laundry	.60	.67	.45	.35	.53	.49	.47	.48	.60	.46	.36	.48
Plant Operation	1.69	1.91	1.74	1.09	1.92	1.65	1.20	1.36	1.49	1.19	1.04	1.21
Medical & Surgical	.39	.86	1.46	.32	.93	1.07	.35	1.29	2.16	1.41	1.20	1.48
O. R. & Del. Rms.	.72	1.24	1.27	.85	.88	.74	.80	1.54	1.27	1.74	1.66	1.52
Pharmacy	.82	1.26	.65	.65	.98	.78	.21	.89	.92	2.05	.89	1.50
Nursing	5.99	6.15	5.56	3.59	5.14	4.52	4.25	4.97	5.34	7.84	4.33	5.17
Anesthesia	.24	.80	.58	.43	.48	.51	.41	.44	.59	.71	1.01	.61
Laboratory	.54	1.02	1.03	.52	1.24	.71	.42	.96	.83	.63	.92	1.49
X-ray	.65	1.76	.96	.58	1.26	.75	.20	.65	.74	.86	.70	.78
Other special services	.01	.22	.94	.64	.61	.66	.73	.19	.53	.64	.59	.22
TOTAL EXPENSES	39,106	98,035	792,660	86,095	510,354	721,691	35,672	50,534	1,101,949	96,869	311,343	835,399
TOTAL CHARGES TO PATIENTS	40,024	90,356	763,243	85,985	473,255	755,004	35,755	52,980	1,026,612	89,632	323,092	895,557
OPERATING INCOME PER PATIENT DAY	18.38	20.73	22.01	12.68	19.34	18.70	12.79	18.82	19.41	19.80	19.17	22.25
OPERATING EXPENSES PER PATIENT DAY	17.96	22.49	22.86	12.70	20.86	17.88	12.76	19.71	20.83	21.40	18.47	20.76

REGION →	EAST NORTH CENTRAL Illinois, Indiana, Michigan Ohio, Wisconsin			WEST NORTH CENTRAL Kans., Iowa, Minn., Neb., N. D., S. D., Mo.			MOUNTAIN STATES Ariz., Colo., Idaho, Mont., Nev., N. M., Utah, Wyo.			PACIFIC COAST California, Oregon, Washington		
NO. OF BEDS	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up	1-100	101-225	226-up
AV. NO. OF ADULT PATIENT DAYS	1,562	3,431	8,737	2,154	4,316	14,570	1,428	3,240	5,162	1,574	3,970	6,740
% of OCCUPANCY	73.01%	76.44%	81.37%	77.50%	77.23%	86.66%	62.23%	72.07%	67.79%	68.59%	66.35%	72.07%
EXPENSES BY DEPTS.		Per Patient		Day				Per Patient		Day		
Administration	$1.91	$2.79	$2.55	$1.47	$1.78	$1.98	$1.31	$1.83	$2.10	$3.37	$4.53	$4.10
Dietary	2.66	3.35	3.44	2.38	3.25	3.04	2.62	2.95	3.33	3.83	3.87	4.36
Housekeeping	.87	.90	1.66	.78	1.04	.91	.84	.92	.79	1.67	1.68	1.57
Laundry	.59	.54	.62	.59	.49	.31	.56	.51	.53	.54	.82	.71
Plant Operation	1.41	2.12	1.54	.99	1.39	1.62	1.01	1.33	.95	1.04	1.90	1.81
Medical & Surgical	1.03	1.41	1.36	.62	.91	.78	1.23	2.10	1.56	.86	1.80	2.35
O. R. & Del. Rms.	1.06	1.09	1.27	.59	1.34	1.75	1.12	1.06	1.50	1.31	2.43	2.55
Pharmacy	1.03	.83	1.17	1.32	1.27	.77	1.87	1.84	1.27	.80	1.27	1.90
Nursing	5.29	5.98	6.38	3.78	5.17	5.43	4.79	3.58	5.15	6.61	9.05	8.12
Anesthesia	.40	.46	.48	.12	.51	.47	.29	1.02	.27	.27	.85	.53
Laboratory	.80	.91	1.08	.46	1.11	.87	1.36	1.41	1.12	1.78	2.01	1.85
X-ray	1.08	1.06	1.11	.52	.68	.48	.96	1.09	1.01	2.24	1.11	1.73
Other special services	.48	.66	.67	.47	.58	.49	.27	.52	.33	—	1.09	.31
TOTAL EXPENSES	224,233	372,159	611,147	74,155	910,533	811,780	26,061	192,466	305,630	76,116	639,711	641,097
TOTAL CHARGES TO PATIENTS	217,626	380,745	610,822	172,819	908,529	771,233	28,152	192,891	331,517	83,316	607,687	634,285
OPERATING INCOME PER PATIENT DAY	17.42	22.19	23.30	13.37	19.14	18.43	18.25	19.85	21.41	26.47	30.62	31.37
OPERATING EXPENSES PER PATIENT DAY	17.95	21.69	23.32	13.47	19.18	18.57	19.71	19.80	19.73	24.19	32.23	31.71

One Nurse Does the Job of Many!

THE *New* HAUSTED WAY





THE "EASY-LIFT" NOW HAS TRENDELENBURG POWER-LIFT

A new and important addition to the labor-saving Hausted "Easy-Lift" stretcher is the Power-Lift mechanism that enables a nurse to raise the stretcher to trendelenburg position by simply turning the new Power-Lift Crank.

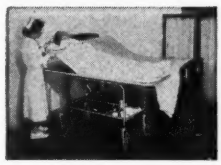
Special full length side rails and shoulder stops make stretchers adaptable for recovery and emergency use.

THE HAUSTED "EASY LIFT" WHEEL STRETCHER

The Hausted Wheel Stretcher is the most revolutionary new development in stretchers ever offered. NOW, FOR THE FIRST TIME, HOSPITALS CAN PURCHASE ONE UNIT TO DO ALL THE JOBS OF PATIENT TRANSPORTATION NEEDED. The Hausted "Easy Lift" requires only one nurse to care for even the heaviest patient. And, what's more, with this unit no physical exertion is required of hospital personnel - the stretcher does all the work. By turning one control the patient is transferred from stretcher to bed, quickly, easily, and safely. The unit is available in Silver-Lustre finish. The Hausted stretcher easily adjusts to the height of any Hospital Bed. Stretcher width is 26 inches and length is 72 inches. THE HAUSTED "EASY LIFT" STRETCHER IS IDEAL FOR POST-ANESTHESIA AND RECOVERY ROOM.

INTRAVENOUS ATTACHMENT

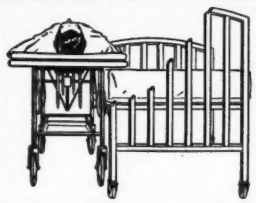
No longer need we see the presently familiar sight of a nurse walking beside a stretcher holding a bottle of fluid in the air. The Hausted attachment eliminates the need for an extra nurse.



THE FOWLER POSITION

By adding the Fowler attachment the Stretcher can be put into proper position in a matter of seconds. This stretcher meets every requirement in transferring patients.

THE TOP FITS OVER THE BED

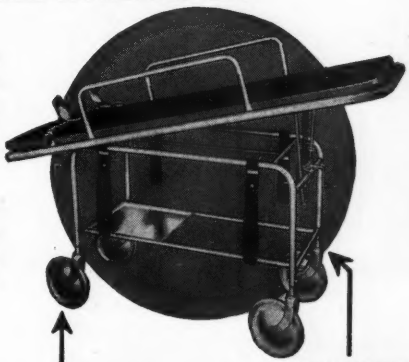


This is the feature that distinguishes Hausted Wheel Stretchers. The stretcher top fits 3¾ inches over the edge of the bed for easier, quicker, and safer patient transfers. The Hausted Standard Stretcher enables just two nurses to transfer even the heaviest patient without fear of disturbing or harming the patient and without strain to the attendants.

THE HAUSTED LOW COST STANDARD WHEEL STRETCHER

This new, low-cost STANDARD STRETCHER provides hospitals with the answer to easier patient transfers. Its sturdy construction and its versatility are the results of careful engineering and research into hospital needs.

The Standard Stretcher's over-the-bed feature is outstanding among its many advantages. Special side rails are available for post-operative or spinal anesthesia use.



AVAILABLE IN 4 CASTER COMBINATIONS

THE HEIGHT ADJUSTS FROM 31 TO 38 IN.

GET THE HAUSTED FACTS NOW!

Contact your Hospital Supply Dealer or write to us direct for descriptive literature and prices.

OTHER VALUABLE FEATURES - -

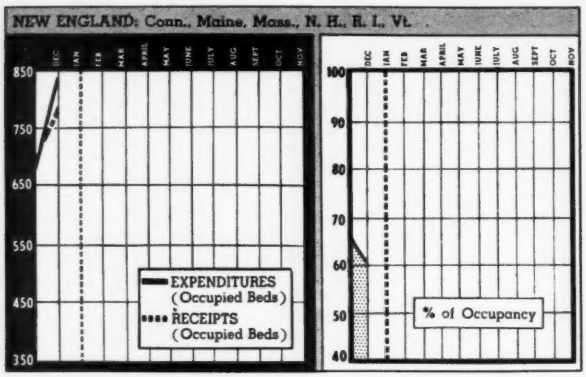
- SAFETY SIDE RAILS
- ADJUSTABLE AND REMOVABLE SHOULDER STOPS
- FOWLER ATTACHMENT
- INTRAVENOUS ATTACHMENT
- RESTRAINING STRAPS
- TRENDELENBURG POWER LIFT

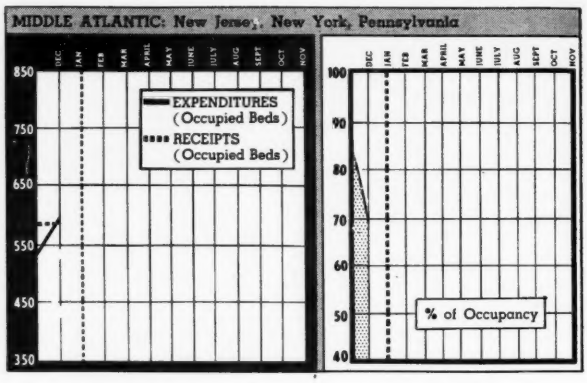
HAUSTED WHEEL STRETCHER

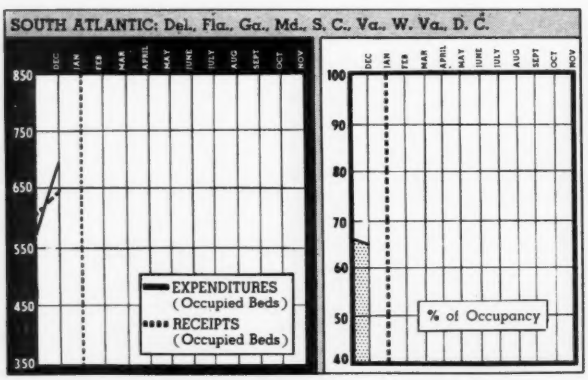
PAT. APPLIED FOR

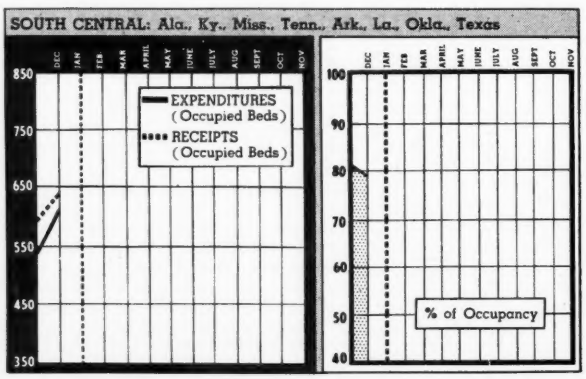
HAUSTED
MANUFACTURING COMPANY
MEDINA, OHIO

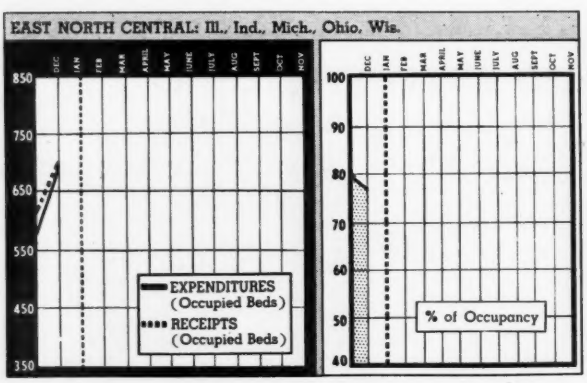
regional charts for December-1951

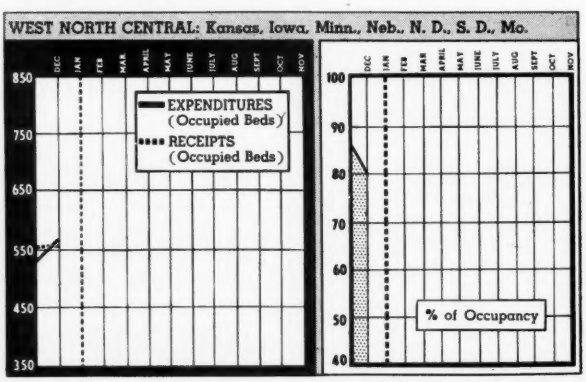


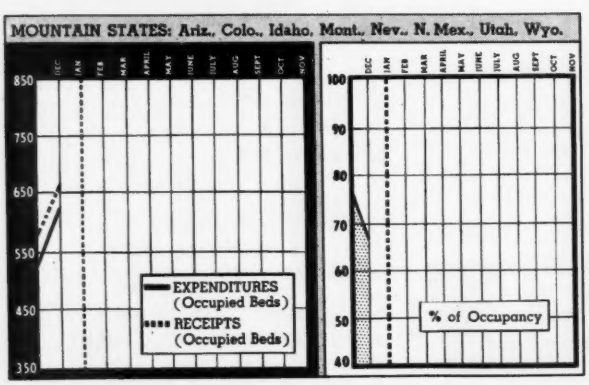


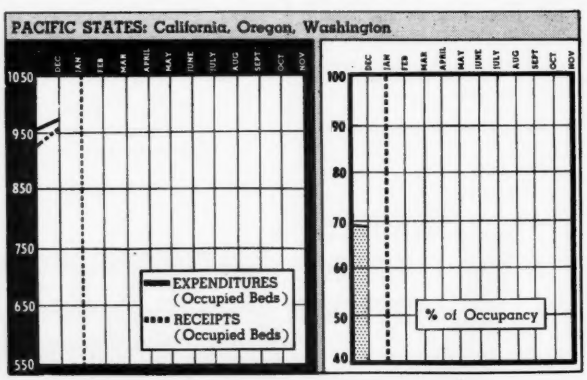


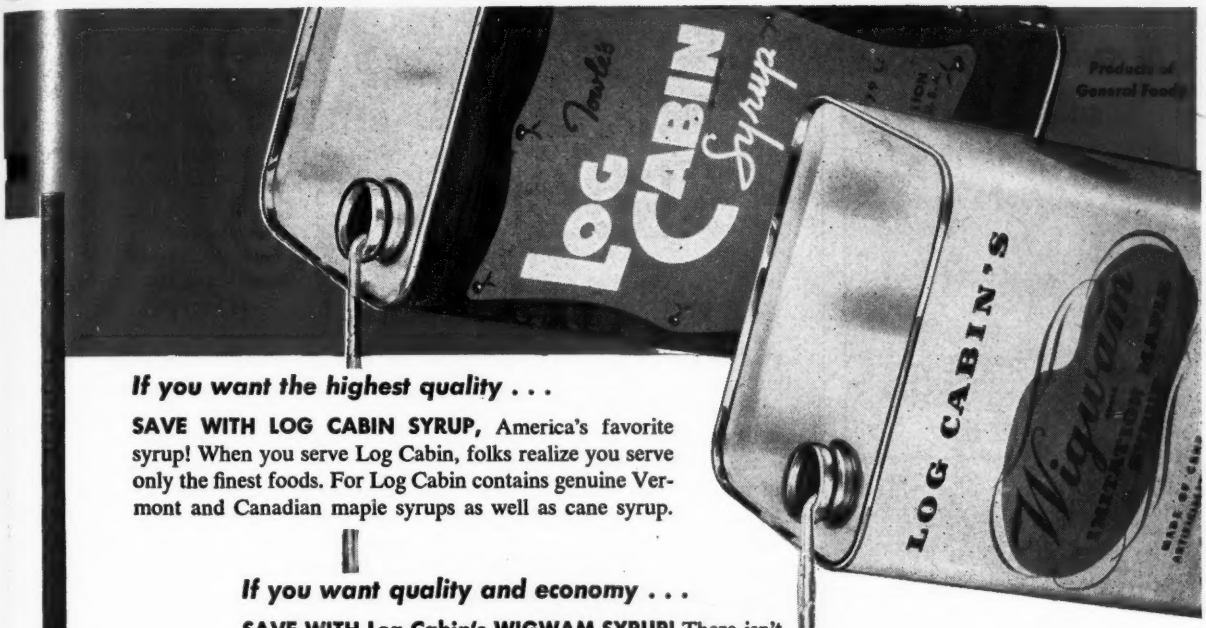







MOUNTAIN STATES: Ariz., Colo., Idaho, Mont., Nev., N. Mex., Utah, Wyo.
EXPENDITURES (Occupied Beds)
RECEIPTS (Occupied Beds)
% of Occupancy





If you want the highest quality . . .

SAVE WITH LOG CABIN SYRUP, America's favorite syrup! When you serve Log Cabin, folks realize you serve only the finest foods. For Log Cabin contains genuine Vermont and Canadian maple syrups as well as cane syrup.

If you want quality and economy . . .

SAVE WITH Log Cabin's WIGWAM SYRUP! There isn't a syrup on the market that can offer you as much as Wigwam for such a truly low price. Many people prefer Wigwam to real maple syrup.

PANCAKES
7¢ to 11¢ per portion including butter and syrup

WAFFLES
about 9¢ per portion including butter and syrup

. . . AND MAKE TALK WORK FOR YOU! When you serve a *favorite* brand like Log Cabin, you can be sure folks will enjoy and talk about your fine food. That's why it's a good tip for you to specify General Foods Institution Products. For these famous products include the special institution blend of Maxwell House Coffee, America's *favorite* brand of coffee, and Jell-O, America's *favorite* gelatin dessert. The people you serve have enjoyed General Foods products in their own homes for years and years.

DEPENDABLE SERVICE

SINCE 1909

DIACK

Increasing Popularity of Diack Controls is shown by 1951 sales exceeding 1940 sales *six times over.*

TIME-TRIED Diack Controls

SMITH AND UNDERWOOD
Sole Manufacturers
Diack Controls and Inform Controls

letters

Instructive, stimulating

■ TO THE EDITOR: After reading the instructive article in the October issue of HOSPITAL MANAGEMENT on annual reports I am taking the liberty of forwarding to you under separate cover a copy of our latest annual report.

This is the first attempt that has been made by this hospital to present a more readable annual report than is the custom in this country. Our previous annual reports have consisted of much detail, photographs of no particular interest and a great many unrelated statistics. If you have a "most improved annual report award" I feel sure that we would qualify for it.

I will continue to forward to you each year copies of our annual report, more particularly, since some of the ideas that will be used in future issues will be derived from your articles. . .

Allow me in conclusion to say how stimulating I find your journal which, I feel sure, is testified to by the fact that I have renewed my subscription on a three-year rather than just a one-year basis.

Douglas Pettinger, M.B., B.S.
Assistant Medical
Superintendent.
Royal Alexandria Hospital
for Children,
New South Wales,
Australia.

How to enter public relations contest

■ TO THE EDITOR: We have a very unique public relations program going on at the moment and I would ask what I must do to submit it to your public relations program. . .

J. A. Blaha,
Superintendent.
Lockport City Hospital,
Lockport, New York.

■ EDITOR'S NOTE: Contending for the Malcolm T. MacEachern Citations . . the three large bronze plaques given to first place winners in the HOSPITAL MANAGEMENT public relations competition . . is simply a matter of doing a good public relations job and then telling about it so that the board of judges can judge it adequately.

Judging from past experience, the judges like to see a nicely rounded approach to this matter of public relations. It isn't just a matter of getting things in the newspapers. It isn't all a matter of getting things on the radio or in television. It isn't simply a matter of speeches by hospital personnel before local groups. It is more than a public relations program through hospital personnel. It is more than good hospital service or good hospital food.

Good hospital public relations includes all of these things and more. When the public . . your public . . understands what you are trying to do and likes what you are trying to do then the public will be on your side, enthusiastically, because what you are trying to do is to benefit the public.

So when you start making up your album or albums or poster or posters to show what you have done during the year prior to July 1, 1952, keep these points in mind.

If the administrative job does not allow you the time to do an adequate job on this thing then you should get help. Among the possibilities is a member of the board who knows about these things, or the advertising manager in a company controlled by a member of the board, or an alert member of the auxiliary, or an administrative assistant or a public relations director.

All entries are returned. Therefore you have a permanent record of the year's public relations work.

Keep a file of these albums. They are useful in planning future programs.

All entries must be shipped by midnight of June 30, 1952. They should be sent to:

Editorial Dept.
Hospital Management
200 E. Illinois St.
Chicago 11, Ill.

Now don't forget there also is an annual reports competition. Here, too, bronze plaques (three of 'em) will be awarded. The same time limit applies here.

Three plaques are awarded in each competition. One is given to first place among hospitals with less than 200 beds, one to hospitals with 200 to 400 beds and one to hospitals with more than 400 beds.

The judges also award honorable mention certificates to entries which deserve special consideration but which were not quite good enough to be first.

If there are any further questions don't hesitate to ask.

Thank you for those kind words!

■ TO THE EDITOR: Your very excellent article on page 40 of the December issue re 5% tax on corporate income should be read by every Community Chest secretary in the country!

Carl P. Wright,
Superintendent.
General Hospital of Syracuse,
Syracuse, New York.

■ CORRECTION: It has been called to the attention of the editors that the credit line of "Ten Commandments from Mount Sinai" (December, 1951 HOSPITAL MANAGEMENT, page 56) is now inaccurate. At the time the piece was written, the author, Mark Berke, was the assistant director of Mount Sinai Hospital of Cleveland. Since that time, however, Mr. Berke has become administrator of Mount Sinai Hospital of Philadelphia . . the post he now holds. ■

Reprints

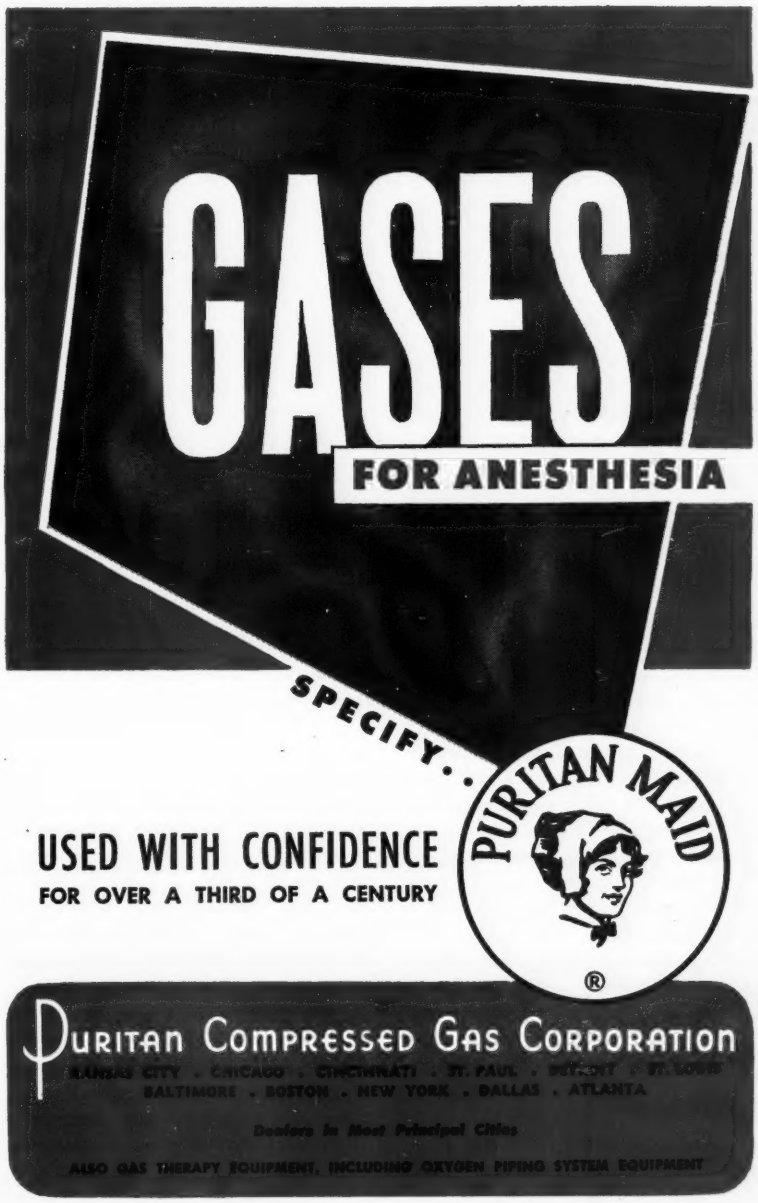
■ TO THE EDITOR: The writer is interested in obtaining reprints on three articles printed in your magazine titled "Manual on admitting office procedure explains details of system." As mentioned, this article was printed in three separate editions as follows: March 1945, April 1945 and May 1945. . .

George Wm. Graham, M.D.,
Assistant Director.
Strong Memorial Hospital,
Rochester, New York.

Many thanks

■ TO THE EDITOR: The Librarian of Congress has requested me to acknowledge, with many thanks, the gift (HOSPITAL MANAGEMENT, volume 71, January-June 1951) which you have so generously made to the Library.

Frances F. Page
for Alton H. Keller,
Chief, Exchange and Gift Division.
The Library of Congress,
Washington, D. C. ■


GASES
FOR ANESTHESIA
SPECIFY..
PURITAN MAID
USED WITH CONFIDENCE
FOR OVER A THIRD OF A CENTURY
PURITAN COMPRESSED GAS CORPORATION
KANSAS CITY . CHICAGO . CINCINNATI . ST. PAUL . DETROIT . ST. LOUIS
BALTIMORE . BOSTON . NEW YORK . DALLAS . ATLANTA
Dealers in Most Principal Cities
ALSO GAS THERAPY EQUIPMENT, INCLUDING OXYGEN PIPING SYSTEM EQUIPMENT

"...to talk of many things"

How one hospital examined its personnel problems

■ THE ADMINISTRATOR of a 50-bed eastern hospital, looking for a way to improve hospital service, took the direct step of sending a questionnaire to all hospital personnel except supervisors, asking pertinent questions. The questionnaire was accompanied by a letter signed by the administrator.

The letter read:

"In an effort to create a closer understanding of the problems of everyone, I have drawn up a questionnaire for the members of our full-time personnel.

"Will you read this through and cooperate by returning same to my desk not later than (date inserted)? Your signature is optional."

Here are the questions asked in the questionnaire:

1. Do you like your position?
2. If you have suggestions which would, in your mind, improve working conditions please state same.
3. Do you refrain from destructive criticism?
4. a. Do you try to give constructive criticism?
   b. Do you try to give constructive criticism to the source where it will be most helpful?
5. Do you ever try to put yourself in the place of your co-workers?
6. Do you take care of hospital equipment, furnishings, etc., as you would your own?
7. Do you turn out unnecessary lights?
8. Will you write here any recommendations which you feel would be helpful for the general improvement of the hospital?
9. Write here how we can help you.

Fifty per cent of the personnel replied to the questions.

The replies were divided according to departments and meetings were held by department personnel to discuss the suggestions applying to each department.

The following steps were taken to solve problems brought to light by the questionnaire:

Nursing service department . . Off duty time for the nurses' helpers (an auxiliary group) was posted ahead for the week instead of by the day.

Same group was given a bonus for nights "on call."

Entrance near dressing rooms was opened earlier each morning.

Patients' semi-private accommodations were permitted to have special duty nurses if they wished.

Telephone service . . Doctors and supervisors were reminded to state the plan of their route through the buildings to save time in locating them. The hospital has no call system.

An intercommunicating telephone was installed from the main kitchen to the floor serving kitchens, thus saving time and lines on the switchboard.

Head phone was obtained for the operator to allow the operator to continue desk work.

Dietary department . . Rotation of weekend for one person who presumably had not wanted it.

Business office . . Pay day changed in order to have the time cards complete three days ahead.

Office hours schedule rearranged to give better service.

Maintenance department . . Stronger electric light bulbs installed in strategic places.

Final result . . Improved cooperation among all and better understanding of mutual problems.

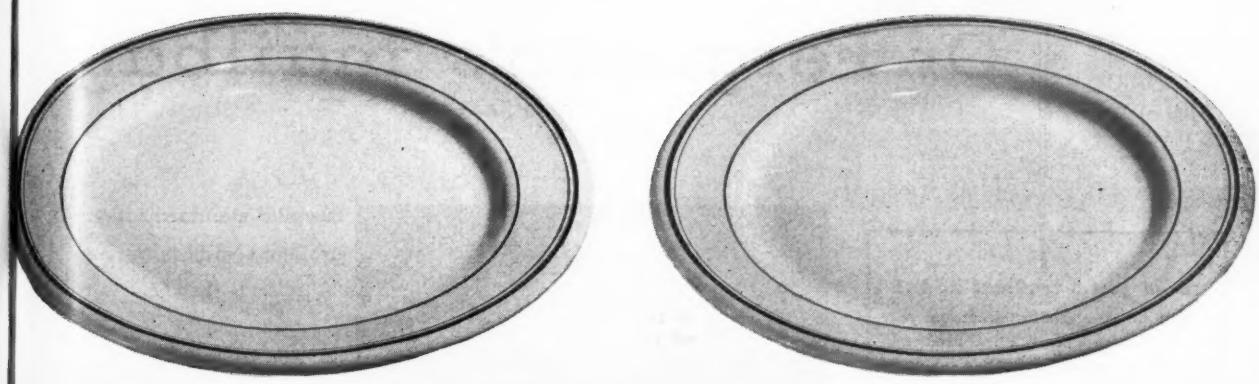
It was amazing to see how many things could be overlooked due to the pressure of too much business, crowded quarters and personnel shortages. ■

More on personnel

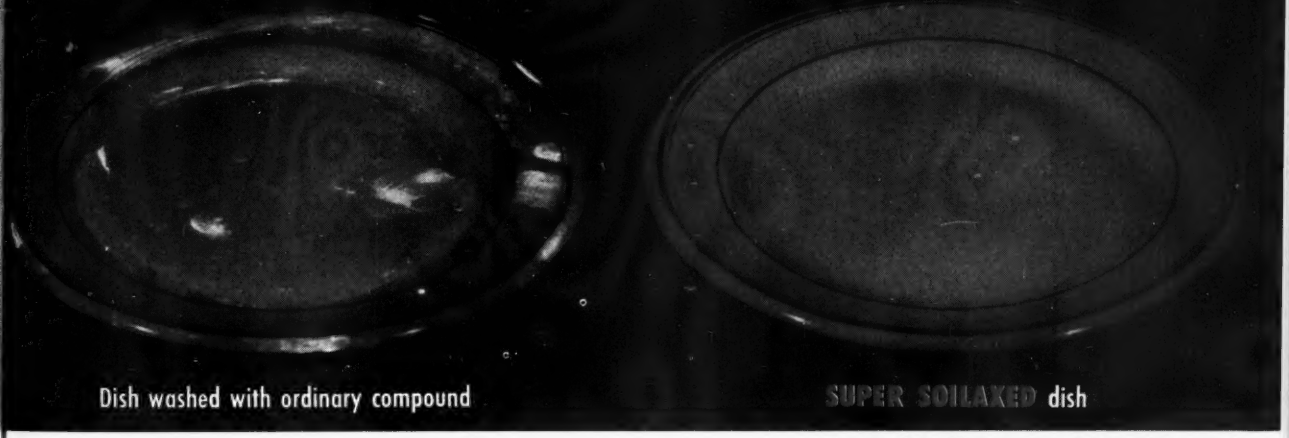
■ PERSONNEL PROBLEMS never loomed so strongly on the hospital horizon as they do today. It is for this reason that HOSPITAL MANAGEMENT is glad to be able to provide its readers with so much good, practical comment on this important subject in current issues.

In this issue, for instance, in addition to the material on this page, of particular interest to small hospitals as well as large, there are other pertinent articles on page 41, 81 and 86. ■

WHICH IS THE CLEAN DISH?



BLACK LIGHT TELLS YOU THE TRUTH!



Dish washed with ordinary compound

SUPER SOILAXED dish

Unretouched Photos. Ultra-violet equipment and technical assistance, courtesy General Electric Company.

PROOF THAT THE SUPER SOILAXED DISH is the SANITARY DISH!

THAT'S RIGHT...you can't fool "black light"! No matter how clean utensils may appear under ordinary light, when they are exposed to these special rays, all hidden food soil gives off a fluorescent glow. Just look at the *unretouched* photos above!

Repeated laboratory tests like this prove that the Super Soilaxed dish ... or glass ... or spoon ... or cup ... is the *sanitary* one. That's because Super Soilax's powerful chemical action sweeps away all food soil, grease, coffee stains, lipstick. *What's more Super Soilax forms no precipitates of its own* that can cloud glasses, dull china and silver!

Your tableware *really* becomes as *healthfully clean* as its sparkle indicates—when you use Super Soilax. Get the facts about this super dishwashing compound and the Super Soilax Service that backs it up. Write for Free copy of "Dishwashing Dividends."

Remember the Service Behind the Product!

ECONOMICS LABORATORY, INC., ST. PAUL, MINN.

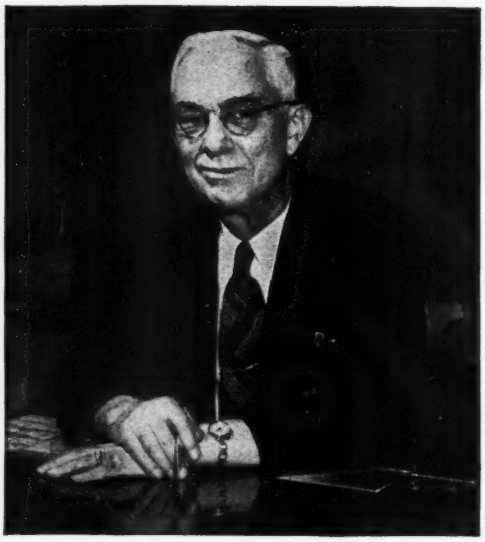
Also manufacturers of TETROX for manual dishwashing, and PAN DANDY—new, activated pot and pan washing compound.

FIRST IN FOOD UTENSIL SANITATION!

Dr. Ferguson's mailbag

Have you a medical audit?

If you have a medical audit in your hospital please send forms used and opinions to me at American College of Surgeons, 40 E. Erie St., Chicago 11, Ill.



Hospital standardization problems and answers

Dr. Paul S. Ferguson, who has succeeded Dr. Malcolm T. MacEachern as director of the hospital standardization program of the American College of Surgeons, and who will continue the work of answering hospital standardization questions on this page

■ PROBLEM: The chief of a surgical staff requests information for the organization of his service, particularly as it pertains to qualifications of the individual surgeons for admission to the senior and to the junior staffs.

■ ANSWER: The senior surgical staff should be made up of physicians who are qualified in every respect for full surgical privileges. These gentlemen should be Fellows of the American College of Surgeons, Diplomates of a Board in Surgery or a surgical specialty, or the equivalent thereof, the latter by training, experience and a record of successful performance in the care of surgical patients.

The junior surgical staff should be made up of those physicians who are qualified for less than full surgical privileges by training, experience and their performance record. Many hospitals follow the practice of placing every new applicant, regardless of his qualifications, in a junior status for a probationary period of up to one year in order that his ability, his professional and financial ethics, how he will get along with other members of the staff, etc. may be determined. This plan appears to work out very satisfactorily.

Of course, the privileges for both the senior and junior surgical staffs should be determined by the credentials committee or other qualifying committee after careful consideration of the candidates individually from the viewpoints named above.

■ QUESTION: A chief of staff writes: Is it necessary or advisable for the administrator of the hospital to attend the monthly medical staff conferences?

■ ANSWER: The superintendent or administrator of a hospital is the official liaison between the governing body and the medical staff of the hospital and as such should be fully aware of the functioning, decisions and wishes of the medical staff. Whether lay or medical administrator makes no difference.

The administrator should attend all staff conferences and, if he is a physician, he may take part in the discussions. In this way he obtains a better knowledge of how the medical staff is functioning and they in turn will better appreciate the problems of the administrator.

It would seem to us that it is the duty as well as the privilege of the administrator to attend the monthly staff conferences and any other meetings of the medical staff in which he may be of assistance to the medical staff and the governing body.

■ QUESTION: A hospital administrator writes: Much is being said about sterilization of both male and female patients. Would you give us your recommendations?

■ ANSWER: The American College of Surgeons recommends that the following procedure be followed in all cases of sterilization:

1. A complete history of the patient with indications for ligation of the tubes or vasectomy clearly and definitely recorded.

2. Sterilization operation to be done only for pathological conditions which might endanger the health or life of the patient and never for social or personal reasons.

3. Recorded consultation of two other members of the medical staff, preferably one of these to be the chief of the service and both acceptable to the management of the hospital and the chief of staff.

4. Careful record of operation when done and complete description of the pathology found.

5. All cases of sterilization to come up for review and analysis by the medical staff at conferences. ■

Will the new commission for hospital accreditation work?

A frank appraisal of the principles that must be followed and the chances of success that impend for the combined program of hospital accreditation

■ PRELIMINARY STEPS in the formation of a new Joint Commission on Accreditation of Hospitals have been completed. With the addition of the Canadian Medical Association to the list there now are five organizations represented. The question uppermost in the minds of hospital administrators and hospital trustees is, "Will it work?"

Hope . . All hospital people devoted to the principle of sound and steady growth hope that the commission will be able to function brilliantly and successfully. They hope its role will be as stimulating and elevating as has been that of the American College of Surgeons for more than a quarter of a century. They hope its leadership will be as devoted to the cause as was the leadership of Dr. Malcolm T. MacEachern. The commission already has manifested a similar hope with a resolution of commendation for Dr. MacEachern on his great leadership.

Peril . . It is no secret among hospital people far and wide, though, that the present stage of developments is somewhat akin to the business of walking on eggs. Can the divergent interests of the cooperating groups be successfully harmonized for the benefit of all hospitals all the time? Or will it end in an out-sized omelet contrived from eggs broken in the battle of separate interests and cooked by the heat of argument?

Warning . . In the face of the threats of socialized medicine it will behoove the five organizations and their representatives to consider well that a common front must be maintained. It will consider well that the public, too, is sitting in on its deliberations and judging its acts. It will consider well the fact that no one group must profit at the expense of any other group. When it moves forward to higher and higher standards of medical and hospital care it must move as a unit.

Unity . . As long as the American College of Surgeons has been the arbiter of hospital practices there has been a certainty that unity would prevail. Here were the standards. Here were the hospitals. Those who met these well defined standards were approved. Those who did not were not. It was as simple as that. The inspectors were the American College of Surgeons inspectors. There was no confusion in their minds as to what the standards were. They were there for all to see.

Question . . Can the commission rise to this high level of achievement? Will the standards be clear-cut? Will the inspectors make their rounds with weapons of high and effective standards, graced with the spirit of unity? Or will the inspectors of the American Medical Association brandish one set of standards and the American Hospital Association inspectors brandish another set of standards to the confusion of the hospital field in general?

We are sure the commissioners will shout a loud "No!" to the latter suggestion. But will that "No!" continue loud and clear or will it echo away and finally be drowned out in the clash of opposing ideas?

Answer . . Thanks to Dr. MacEachern's fine work there isn't much doubt about the sort of standards the hospitals should strive for. Every thoughtful hospital administrator and every thoughtful hospital trustee in this land is hopeful that these standards will be strong, unified, clear-cut and progressive. They hope these standards will be the star which will guide hospitals to ever greater accomplishment, the best antidote we know for the poison of government controlled medicine.

Factors in the control of length of stay

A detailed analysis of V-A experience that carries over to other hospitals as well

by **Harold A. Press,** M.D. Director, Program Analysis Staff
Daniel I. Rosen Chief, Medical Statistics Division
William B. Tollen Chief, Administrative Statistics Section, Medical Statistics Division
Morton Robins Chief, Biometrics Section, Medical Statistics Division
Veterans Administration • Washington, D.C.

■ WITHIN THE LAST FEW YEARS much concern has been voiced with regard to a presumed significance in the difference between the duration of hospital care given to patients in V-A hospitals as compared to that given in private hospitals. The difference that has caused all this concern is a matter of record, so it is pointless to deny its existence.

It is very important, however, that three questions be answered before attempting to draw any conclusions: (1) What is length of stay? (2) Who are the patients being treated in the different hospital systems? and (3) How are the patients being treated?

Length of stay . . Ordinarily the term "length of stay" is considered to mean the average number of days spent in hospital by a group of patients from admission to discharge. It is derived by adding together the number of inpatient days for all patients discharged during a particular interval and dividing by the number of such patients.

This measure is a mathematical one and quite often has little meaning in actual observation. No single patient may have experienced this particular stay, and no two patients whose experience is included in the computation of the ratio may have the same disease or be similar biological entities in terms of such factors as age, physical status, *et cetera.*

To compare the length of stay of patients discharged from the same hospital during two different time periods, or to make this comparison for patients discharged from two different hospital systems, or to show the trend of this computed figure for the same hospital system without paying attention to the characteristics of the patients whose experience is being so summarized, is to demonstrate differences which no amount of analysis can decipher and which usually result in erroneous conclusions.

For example, Chart 1 shows the average length of stay of all patients discharged from Veterans Administration hospitals during each fiscal year from 1923 through 1950. The solid line represents the total experience of all patients discharged each year. The dashed and dotted line represents the V-A experience with veterans of World War II, and the dashed line shows experience with patients with eligibilities that have arisen from their service prior to the second World War.

Pertinent factors . . This is an interesting picture, but what does it mean? The experience for all patients over this 28-year period moves up and down in response to all sorts of influences. In 1933 the so-called "Economy Act" restricted admissions of patients to V-A hospitals, and so in 1934 a relatively higher proportion of the discharges had to be the longer staying patients who were admitted prior to that year. Consequently, the length of stay increased.

Immediately thereafter, the repeal of this Act brought large numbers of patients into V-A hospitals, many of whom could not possibly have stayed very long, and so the average stay went down. In general, it may be said that the average length of stay will usually decrease when there is any sudden increase in admissions . . and conversely, if any restrictions are placed on admissions, length of stay goes up.

Another observation . . Subsequent to 1943, it appears that we have effected marked reductions in the average length of stay of all patients discharged. However, the length of stay of World War II patients discharged showed relatively no change over this same period. Moreover, the average length of stay of other than WW II patients actually increased precipitously through 1947, and after that began dropping but still maintained a level above that for 1944. Thus, it is seen that while the average length of stay for all patients discharged showed a steady decline, the length of stay for each of the two major groups of patients comprising the total exhibited quite a different trend during the same period.

This apparent inconsistency principally results from the fact that the proportion of relatively short-term, WW II patients increased markedly over the past seven years. This increasing proportion of patients with short stay assumed a more and more noticeable effect on the average stay experience for all patients.

At this point the question of computing either a "turnover rate," or a "ratio of admissions to operating beds," or an average length of stay, should be considered briefly. While each of these statistical tools rep-

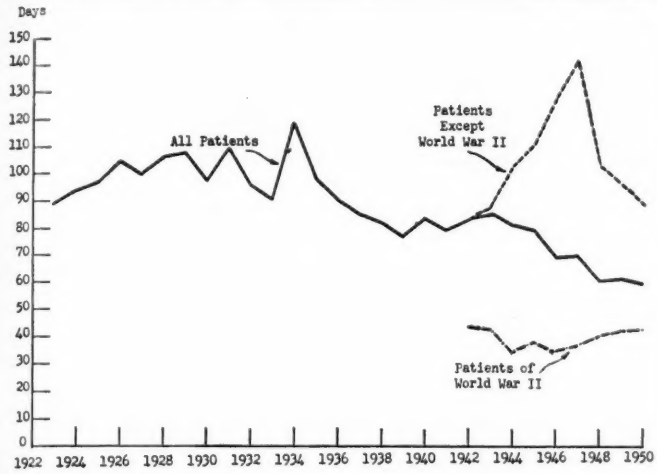


Chart 1 . . Average length of stay of patients discharged from Veterans Administration hospitals . . during the fiscal years 1923-1950

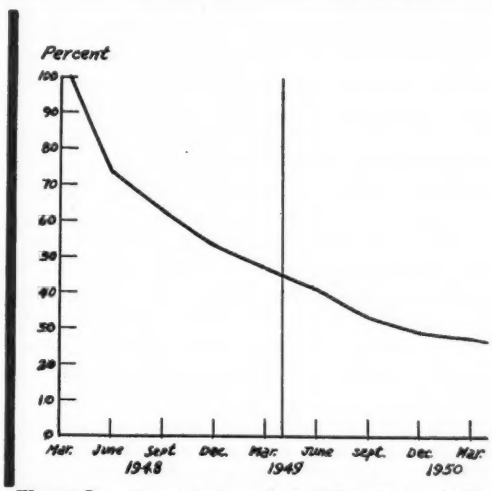


Chart 2 . . Per cent of psychotic V-A patients admitted April, 1948 and continuing treatment through April, 1950

resents a crude index which is useful for purposes of hospital management, it should be recognized that the average length of stay has important advantages over the two other commonly employed indices.

Principally, length of stay analyses can be made specific for the characteristics of the patient load which are believed to affect patient flow, such as, in the case of the Veterans Administration: age or war, race, sex, and diagnostic class. A more refined analysis of "turnover rates" or the "ratio of admission to operating beds" is usually not possible because of the fact that information on the characteristics of currently hospitalized patients, or of types of beds, is generally limited to the broad categories of medical services.

Relationship of expected length of stay . . As indicated previously, average length of stay serves as a crude index for purposes of hospital management. However, its usefulness and validity generally are dependent upon the relationship between the computed figure and a statistic which refers to the *expected* length of stay of a group of current admissions. For example, the median length of stay for psychotic patients discharged from the V-A hospital system is found to be about 70 days. That is, of all psychotic patients discharged, half of these patients were hospitalized longer than 70 days. Compare this figure with that observed when a sample group of psychotic admissions are followed through their hospital experience. (This type of analysis is generally referred to as a "cohort study.")

Chart 2 shows the story for a sample group of patients with functional psychoses admitted to V-A hospitals during April 1948 and followed for two years. It should be noted that although the median length of stay of those patients discharged is 70 days, almost one-half of these admissions were still in hospital at the end of the first year.

A similar discrepancy is observed when the average length of stay of a group of chronic patients discharged in a period is compared with the expected length of stay of similiar patients currently being admitted. For example, the average length of stay of psychotic patients currently being discharged is approximately 1¼ years, whereas it is estimated that the average expectation of stay for a group of current psychotic admissions is probably somewhere between 8-10 years.

Comparisons between different hospital systems . . The other matter which must be considered is the purpose for which various medical organizations have been established. The medical services of the Armed Forces are set up to provide *complete* medical care to military personnel who, because of illness, are incapacitated for full active duty. Consequently, one of the functions of the military hospitals is to provide hospital care for relatively minor illnesses and for periods of convalescence.

Again, at such time as a member of the Armed Forces is about to be discharged from the service for disability, the military hospital becomes an evaluation mechanism and so patients must of necessity be retained past the point where the purpose of their stay is purely hospital treatment.

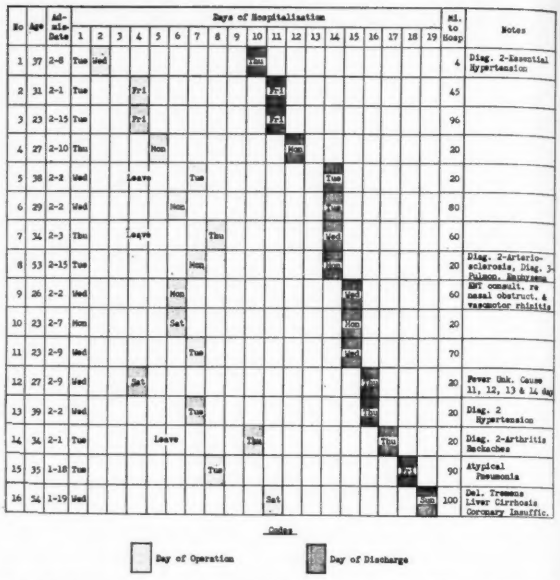
A non-Federal, private hospital, on the other hand, is established to provide inpatient medical care to a population who, in general, have other sources from which they can receive medical attention. When a civilian is ill enough to require hospital care, and can afford to pay all or part of the cost, he generally is admitted to a hospital, accompanied or preceded by his physician, who has an exact and immediate knowledge of the history and current status of the patient.

Treatment can begin promptly and a whole series of economic factors are immediately put into play, the action of which tends to force the patient out of the hospital at the earliest possible moment. In addition, the patient's physician is continuously available on call and can visit the patient at his home. Therefore, the convalescent period is usually not spent in hospital.

Veterans Administration hospital services are somewhere between these two extremes. In most instances the admitted patient is a medical unknown. He has

not been seen prior to admission, and he may have travelled a long distance to be admitted. The Veterans Administration is also bound by legal requirements which make it very difficult to provide convalescent care outside the hospital. Moreover, the V-A patient is discharged after receiving treatment for all disabilities which are amenable to therapy, not merely the one which acted as the precipitating cause for his hospitalization.

Chart 3 . . Length of stay of herniotomy cases in a V-A hospital . . 1949


No
Age
Admis. Date
Days of Hospitalization
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
Mi. to Hosp
Notes
1 37 2-8 Tue Wed 4 Diag. 2-Essential Hypertension
2 31 2-1 Tue Fri 45
3 23 2-15 Tue Fri 96
4 27 2-10 Thu Mon 20
5 38 2-2 Wed Leave Tue Tue 20
6 29 2-2 Wed Mon Wed 80
7 34 2-3 Thu Leave Thu Wed 60
8 53 2-15 Tue Mon Mon 20 Diag. 2-Arteriosclerosis, Diag. 3-Fulson. Emphysema
9 26 2-2 Wed Mon Wed 60 ENT consult. re nasal obstruct. & vasomotor rhinitis
10 23 2-7 Mon Sat Mon 20
11 23 2-9 Wed Tue Wed 70
12 27 2-9 Wed Sat Fri 20 Fever Unk. Cause 11, 12, 13 & 14 day
13 39 2-2 Wed Tue Fri 20 Diag. 2 Hypertension
14 34 2-1 Tue Leave Thu Thu 20 Diag. 2-Arthritis Backaches
15 35 1-18 Tue Tue Fri 90 Atypical Pneumonia
16 24 1-19 Wed Sat Sun 100 Del. Tremens Liver Cirrhosis Coronary Insuffic.
Codes
Day of Operation
Day of Discharge

Approaches to the problem . . The Veterans Administration has been actively aware of the problem of length of stay since about 1945. Then, in the face of a rapidly rising demand for admission, bed capacity was expanding too slowly. The Veterans Administration was forced to think about the length of time that general medical and surgical patients were retained in hospital. Certain steps had to be taken to reduce length of stay.

Chart 4 . . Length of stay of herniotomy cases in a university hospital . . 1949

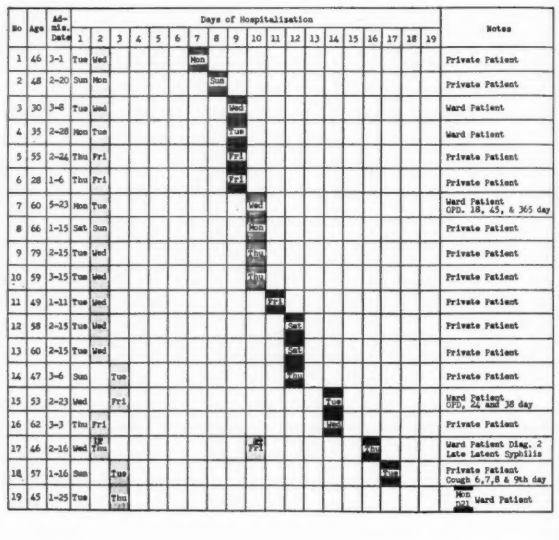
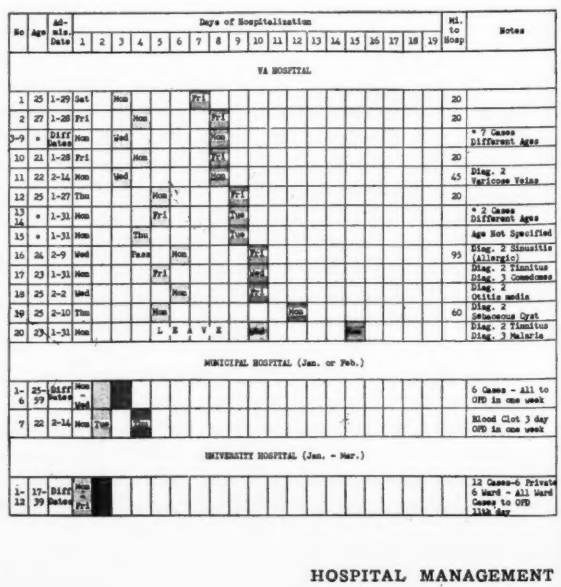

No
Age
Admis. Date
Days of Hospitalization
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
Notes
1 46 1-1 Tue Wed Private Patient
2 48 2-20 Sun Mon Private Patient
3 30 2-8 Tue Wed Ward Patient
4 35 2-28 Mon Tue Ward Patient
5 55 2-24 Thu Fri Private Patient
6 28 1-6 Thu Fri Private Patient
7 60 5-23 Mon Tue Ward Patient OPD. 18, 45, & 365 day
8 66 1-15 Sat Sun Private Patient
9 79 2-15 Tue Wed Private Patient
10 59 3-15 Tue Wed Private Patient
11 49 1-11 Tue Wed Private Patient
12 58 2-15 Tue Wed Private Patient
13 60 2-15 Tue Wed Private Patient
14 47 3-6 Sun Tue Private Patient
15 53 2-23 Wed Fri Ward Patient OPD, 24 and 28 day
16 62 3-3 Thu Fri Private Patient
17 46 2-16 Wed Ward Patient Diag. 2 Late Latent Syphilis
18 57 1-16 Sun Tue Private Patient Cough 6,7,8 & 9th day
19 45 1-25 Tue Thu Mon Ward Patient

Chart 5 . . Length of stay by tonsillectomy cases . . 1949


No
Age
Admis. Date
Days of Hospitalization
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19
Mi. to Hosp
Notes
VA HOSPITAL
1 25 1-29 Sat Mon Fri 20
2 27 1-28 Fri Mon Fri 20
3-9 " Diff Dates Mon Wed Mon * 7 Cases Different Ages
10 21 1-28 Fri Mon Fri 20
11 22 2-14 Mon Wed Mon 45 Diag. 2 Varicose Veins
12 25 1-27 Thu Mon Fri 20
13 14 " 1-31 Mon Fri Tue * 2 Cases Different Ages
15 " 1-31 Mon Thu Tue Age Not Specified
16 24 2-9 Wed Tues Mon Fri 95 Diag. 2 Sinusitis (Allergic)
17 23 1-31 Mon Fri Wed Diag. 2 Tinnitus Diag. 3 Comedones
18 25 2-2 Wed Mon Fri Diag. 2 Otitis media
19 25 2-10 Thu Mon Mon 60 Diag. 2 Sebaceous Cyst
20 23 1-31 Mon L E A V E Wed Diag. 2 Tinnitus Diag. 3 Malaria
MUNICIPAL HOSPITAL (Jan. or Feb.)
1-6 25-59 Diff Dates Mon Wed 6 Cases - All to OPD in one week
7 22 2-14 Mon Tue Blood Clot 3 day OPD in one week
UNIVERSITY HOSPITAL (Jan. - Mar.)
1-12 17-39 Diff Dates Mon & Fri 12 Cases-6 Private 6 Ward - All Ward Cases to OPD 11th day

In setting up the study it was necessary to face the

problems which were mentioned earlier and answer some additional questions. First of all, what types of patients were going to be studied? It was necessary to define the study group in such a way that it would be reasonably certain that any differences which were observed might be ascribed to administrative or professional practices in the care of those patients and not to extraneous forces. Consequently, it was decided to study the experience of patients for whom the clinical record indicated medical care was given for only one condition and whose hospital course was not affected by any major complications.

Chart 3 summarizes the findings for patients admitted for herniotomy in the selected V-A hospital. A summary of this experience indicates that, out of 16 patients, one was operated on the second day after admission, three on the fourth day, one on the fifth, three on the sixth, four on the seventh, two on the eighth, one on the tenth, and one on the eleventh. With respect to length of stay, one of these 16 patients stayed 10 days, two stayed 11 days, one stayed 12 days, four stayed 14 days, three stayed 15 days, two stayed 16 days and one each stayed 17, 18, and 19 days respectively.

At a municipal hospital in the same city, surgery was generally performed sooner than in the V-A hospital although in only one instance out of ten cases did an operation occur on the day of admission. And in only two others did it occur on the second day.

The experience of a university hospital in the same city is described in Chart 4. In all but four instances these patients were operated the second day after admission. In these four cases, operation occurred on the third post-admission day.

The general conclusions to be drawn from the analysis of the herniotomy study have been demonstrated in almost all of V-A's special analyses. Another illustration is a comparison of the same hospitals as above with respect to patients admitted for tonsillectomy (Chart 5). The same situation is noticeable, but perhaps in a much more striking way. The private hospital provided information on 12 patients, all of whom were operated the day of admission, and discharged the next day. Six of these patients were ward cases; six were private cases. All of the ward cases returned to the outpatient department for check-up nine days after discharge. All of the private cases were given post-hospital care by their own physician at home or in his office.

The story was much the same for the municipal hospital. Here, of seven patients, all were operated on the second day after admission, and with one exception were discharged the next day. All returned for check-up to the hospital outpatient department one week after discharge.

The question as to why operation in the municipal hospital was not on the day of admission, as was the case with the university hospital, is immediately raised. Here we begin to see the influence of one of the factors which lengthens stay in hospitals in the Veterans Administration system. These patients were unknown to the municipal hospital prior to admission, and they too had to be worked up to a greater extent than was necessary for the patients in the university hospital.

In the top section of Chart 5 is shown the experience of the Veterans Administration hospitals for 20 tonsillectomy patients. The earliest day of operation for any of them was the third day. All of the cases except one were operated on either the third, fourth, fifth or sixth day of hospitalization. Special diagnostic procedures and additional diagnoses account, in a number of the cases, for some of this delay, as indicated in the "Remarks" section of the table.

Veterans Administration has explored another aspect of length of stay . . one which may well be a significant approach to the problem, and one which it is possible to use in the Central Office through the medium of records received from V-A hospitals.

The V-A medical records system is roughly the same as that for the other Federal medical services. At the time that a patient is discharged from hospital a copy of the abstract of the clinical record is received. From this the length of stay can be related to the established diagnosis or to any other factors which seem of importance. An analysis of the patterns exhibited by V-A general hospitals in discharging patients on various days of the week, has revealed some very interesting differences which point out that if the model of certain hospitals were adopted by others an improvement in length of stay would most surely result.

In Chart 6 can be seen a series of small bar charts, one for each of several hospitals. The records representing patients discharged from each hospital were accumulated over a period of eight consecutive weeks, and were related back to the day of the week on which the patients were discharged. The graphic representation shows the percentage of all the patients who were discharged on the indicated day. The first bar represents Sunday; the second, Monday; third, Tuesday; and so on.

Observe, first, what is perhaps the best example. The upper right panel represents the V-A hospital at Hines, just outside Chicago. There is evidence here of a well-conceived and -executed program for the discharge of patients which extends quite consistently over a period of six days, giving every evidence that patients in general are discharged as maximum hospital benefit is attained.

The next panel to the right is that of the V-A hospital in San Francisco. It will be noted that quite a difference exists here. Eighty-seven per cent of the patients were discharged on three days . . Tuesday, Thursday, and Saturday. Next to Hines, this is probably the V-A's second-best story, but there is room for improvement. Undoubtedly many patients discharged on Tuesday . . and 32 per cent of discharges occurred on that day . . could have left the hospital on Monday. The practice at this hospital is to hold discharge boards on alternate days, Monday, Wednesday, and Friday, and their actions were represented by discharges on the following day.

Another panel shows the story of the V-A hospital at Indianapolis, and here, too, certain questions may be raised. Thirty-nine per cent of discharges occurred on Tuesday, and there was a marked decrease in activity over the whole weekend, including Monday.

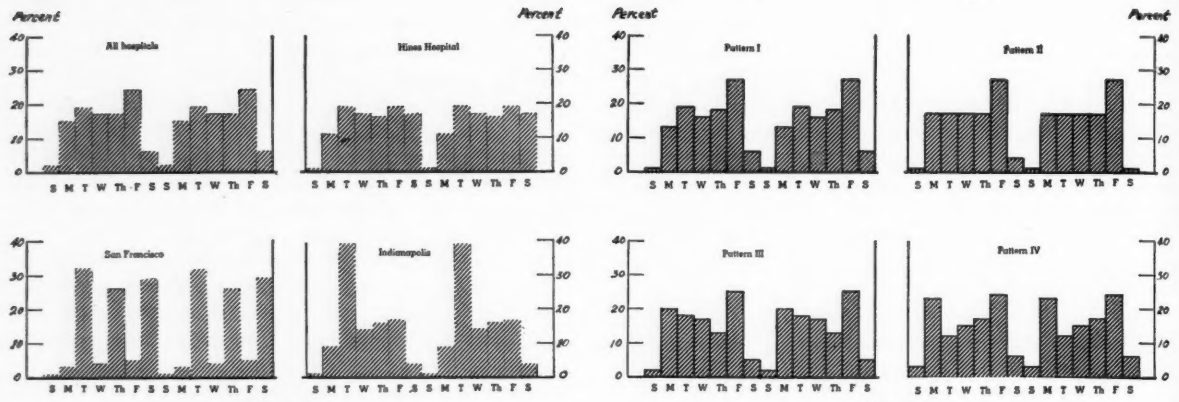


Chart 6

Chart 7

Percentage distribution of discharges by day of week for eight consecutive weeks

Chart 7 shows four major discharge patterns in V-A hospitals. Most hospitals show increased activity on Fridays when a "push" is made to get patients discharged prior to the weekend. In addition Pattern III and especially Pattern IV show substantial Monday activity.

Of course, there is a complementary analysis which must be set up, but this will take more time. This analysis would be of the pattern of admissions. On what days are patients admitted? How long does it take after a patient is discharged until the bed which he has vacated is available for a new patient . . one day? Two days? In short, the entire cycle must be known if we are to determine whether or not there is the most effective possible use of beds.

General conclusions . . In conclusion, length of stay . . that is, shortening length of stay . . is a matter of establishing a state of mind in hospitals. It is felt that this must be done first, before changes in practices or policies will have any effect. Data accumulated in the Veterans Administration's joint study with the Bureau of the Budget clearly indicated the necessity for this.

For example, in a total of more than 200 case studies in seven different hospitals, with a total stay of 6,994 days, it was found that 1,723 (25%) of these days were pre-operative days, of which 634, or more than one-third, elapsed between the completion of work-up and surgery. It was found that 120 days were accounted for by the delay between the date of the discharge order or the doctor's note indicating readiness for discharge, and the day on which the patient actually left the hospital.

At approximately 16 dollars a day, these presumed extra days will represent a substantial cost element; or, looking at it another way, represent a substantial number of bed-days which could be made available for other patients.

Some restraint must be exercised in attempting to shorten length of stay. If, by shortening length of stay, it is found that the readmission rate is increased, nothing has been gained. However, if length of stay is shortened in a legitimate manner by ceasing unnecessary procedures or eliminating needless delays, progress is made. This is a matter which deserves . . and which will get . . a great deal of future study by Veterans Administration.

Hospitalization costs today are high, and the consequences of inactivity in this area are too great to pass over this subject lightly. The matter of length of stay should be included in the curriculum of our schools of hospital administration, if not in that of our medical schools. It is certainly a problem which faces hospital administrators, but which they alone cannot solve.

Another purpose of the statistical study is to determine the facts which are pertinent to answer the allegations which have been made not only against Veterans Administration hospitals but all Federal hospitals . . the allegation that since length of stay in Federal hospitals is longer generally than the length of stay in non-Federal hospitals, Federal hospitals stand convicted of inefficiency, bad medicine, and any other ill which may be fashionable at the moment. It cannot be denied that practices exist in V-A hospitals which, if corrected, would result in a definite shortening of length of stay.

It is not possible to evaluate the experience of the Veterans Administration against that of any other Federal agency, or of any Federal hospital system against any non-Federal hospital or group of hospitals, unless both systems have factors in common. Since length of stay is a figure which represents the end result of many factors working either together or against each other, it has absolutely no significance by itself as a measure of efficiency or effectiveness, and certainly none as a basis for comparing different hospital systems.

As a management tool, length of stay is of inestimable value. It should be used constantly and with progressively increasing effectiveness as we learn more and more about it . . what it is, how it is derived, and how it can best be used. ■

New personnel programs . . a practical view

by Patrick B. Comer, Jr.
Director of Personnel Relations
Druid City Hospital
Tuscaloosa, Alabama

■ MOST AUTHORITIES on business practice agree that an organized program of personnel relations pays real dividends to the institution employing more than 100 people. Industry took the lead in establishing personnel programs under the supervision of one executive or office, and hospital administrators are becoming increasingly aware of the potential and real value to be gained from allocating the responsibility for personnel relations to a single person.

Daniel O. McClusky, Jr.,* says: "Someone is handling personnel problems whether a company has a personnel director or not. The difference in efficiency and happiness of the workers depends on *how* they are handled. If a busy administrator can give only cursory attention to personnel problems, they are not being handled correctly . . *but they are being handled.*"

Mr. McClusky's views on this subject are probably shared by every hospital administrator who decides to create the position of personnel director in his hospital. After the proper man has been employed, many administrators may also share some uneasiness and doubt about how the personnel program will be launched.

How begin? . . Granted that a personnel director may be able to smooth out some of the knotty problems associated with personnel difficulties, how will he get started? What will this new man do?

At first glance this question may not seem to be pertinent . . since the person selected for this position ostensibly knows general personnel theory and has a rather clear idea of what a personnel program should accomplish. The question is very practical, though, for while the initial phase of the personnel plan is not clearly defined it can make or break the venture.

Suppose you are the new personnel director. How fast you proceed and what you will do depends, to some extent, on whether or not you have had previous experience with hospital routine; but . . hospital-wise or hospital-naive . . there are certain principles which should be seen in bold relief. In the first place, it is safe to assume that your appointment would have been deferred for a while if things were running as smooth as silk. So whatever you do, keep your eyes open and step lightly.

With this general orientation, let's examine three cardinal principles of hospital personnel management.

Allegiance . . First, remember that a personnel director is hired by the management to do a job and that he owes primary allegiance to the administration. He isn't hired to pamper the workers or to take sides with people who are disgruntled with the present policies. A vital function of the personnel manager is to interpret administrative policies to the employes in such a way that they are happier on their jobs and have a healthy regard for the administration. Of course, you may have to recommend at times that the policy be changed, but that will come much later in your work.

Employe confidences . . Secondly, the personnel director has a definite responsibility to the employe. While he isn't hired to hold the employes' hands, neither *should* he have been put on the pay roll as a stool pigeon. In fact, if you assume that you were added to the staff for this purpose or if the administrator thinks this is your proper function, the personnel program will fall flat and will be ruined not only for you but for any future personnel director who is brave enough to step into your shoes.

Only a person who has a basic respect for the integrity of people should attempt personnel work. You must be discreet in handling the confidences of people: some things employes tell you should never be repeated to anyone. The employes will test your respect for their confidences in many ways, and you will be richly rewarded if they have not been violated. A personnel director has to have guarded sources of information in order to get the overall picture of many problems. He will be loved if employes know that they can pour out their troubles and resentments to him without fear of these being repeated. And he will be despised if people find that he cannot keep a secret.

Beware haste . . Thirdly, speed kills personnel programs. The wise administrator will accept the inevitable slowness of the first phase of a personnel program. The personnel director is not a magician, and success will depend more upon the rapidity with which he wins the friendship of experienced workers than it will upon his "efficiency."

Of course, it takes more time to make friends than it does to do an efficiency study. You will be frustrated at times, but even if you see ways to improve service the very first day on your job, keep your ideas to yourself until *you* have been accepted. The personnel field is a broad one, and many facets of a single problem are tied in with the personal adjustment or maladjustment of the people whom you must

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understand before you can "manage."

Armed with these three basic principles, you look over your new office and wonder what you will do to justify your salary. Will you walk into the nearest office and start to make job analyses? Will you call a meeting of the department heads and tell them what you can do to make their work more efficient? Will you write mama and tell her that you are a big wheel in a huge concern which deals with the ills and accidents that befall people? What will you do, actually?

Possible antagonism . . There is no hard and fast answer, but it is safe to say that writing mama would be less detrimental to your program than either of the other possibilities mentioned. Adjust yourself to the fact that the people got along without a personnel director for many years (unless you are on the staff of a new hospital), and many of the old-timers probably feel that they could continue to get along without such a "new-fangled" thing.

People will be curious about you. They will wonder after your arrival just what changes will be made, and some will distrust you because they distrust change. The department heads may be afraid that you will usurp their powers or find out too much about the inefficiency of their departments. Some, of course, will expect miracles from you and will welcome you with open arms. You won't be able to tell the two schools of thought apart, though, because the majority of both will be outwardly courteous . . even those who seem abrupt with you may later turn out to be your stalwarts.

Your only sensible approach is to feel your way slowly and with utmost caution. Be friendly but not effusive and make no comments which smack of haughtiness or disapproval. By all means, make the department heads feel that you will not disturb their security or attempt to take away their sovereign authority. Get across the idea that all you have to sell is assistance and service.

Department heads . . The goodwill and cooperation of the majority of the department heads is necessary if a personnel program is to succeed. If too many of them do not want you, you may as well start looking for another position . . for you are almost doomed to failure.

On the other hand, do not be over-sensitive to the disapproval or coolness of one or two of them. Some of the iciest may be the easiest to win over when they see what you are accomplishing. Even if you never win over some of them, don't get bogged down paying too much attention to the squeaking wheel. Some of the major problems that the administration faces probably stem from those departments where the heads do not cooperate in putting over new ideas. As a matter of fact, continued resistance to a new personnel program more than likely indicates that the person fears that shoddy supervision will be discovered.

Dividing time . . Winning over the department heads is only part of the job. A delicate balance must be held between attention to the department heads and their employes, and too much concentration on the "brass" is not a good policy. Complications in maintaining this balance often result because some supervisors will feel offended by or distrustful of the person who tries to establish direct relationships with their workers. You may not be able to walk into the laundry, for example, and talk with the workers without creating some anxiety on the part of their foreman. "What's this fellow up to?" is the question that may pop into his mind.

Holding the other end of the tight rope are the employes, who will be suspicious if you spend so much time with the supervisor that they get only a polite nod as you go to and from his office. This two-edged problem is not as difficult to handle as it may sound, though. Everyone's confidence cannot be won over the first month, but you can be gracious and straightforward in your dealings with people. Time and tact will do the trick.

Cliques . . The problem of cliques may complicate good relations in any hospital. There are various reasons why people working in a hospital will divide themselves into warring groups, so to speak. Some are formed because of historical or "status" reasons. That is, people arriving at about the same time tend to feel a closeness which excludes others, and certain professional groups tend to stick so closely together that they don't feel any identification with others.

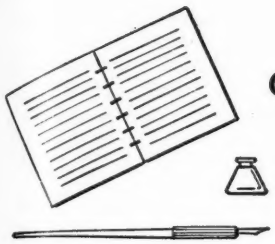
These are feelings that you will eventually want to break down by fostering better understanding among the hospital family. But in the initial phase, it is better to walk with caution rather than to try reform or integration. A safe rule to follow is: criticize no one and do not identify yourself with any particular group.

The administrator is your encyclopedia of *personnel* relations. He will be perfectly frank with you about these conditions if he realizes that many problems cannot be dealt with efficiently without an understanding of the personalities involved. Tell him quite frankly your hunches and let him supply the background. No one can be right in all his guesses, and people whom you initially think are trouble-makers may turn out to be the most solid backers of the hospital while, too often, glib proponents of cooperation are the ones who will actually sabotage good relations. (Some people seem to enjoy creating factions and feuds.) Here is our third principle again: it takes time to learn the total situation, including the personalities of the personnel.

Medical staff . . Now we turn to some of the more slippery aspects of personnel administration . . the medical staff and political pressure. You may wonder what is your relationship to the medical staff and how far you should bend to the whims and "suggestions" of local big shots.

The medical staff may advise the administrator on matters of a medical nature, but personnel practices are the responsibility of the administrator. For instance, the staff may suggest that laboratory technicians should have ASCP registry, but the procurement, salaries, and working hours of these employes are administrative rather than medical problems.

continued on page 92



administrator's diary

by Herbert Krauss

January • 1952

7 We tried out our new gas burner in the boiler room. Works fine, thank you. Should save us tons of soap as we stop pouring coal soot over our own heads.

8 First steel beams arrive and get stacked on one side of the street, which further shrinks parking space available.

21 Now twelve department heads and two directors have looked over and commented on the pamphlet I wrote incorporating the Hospital's personnel policies. On to the printer with it and that project is off my desk.

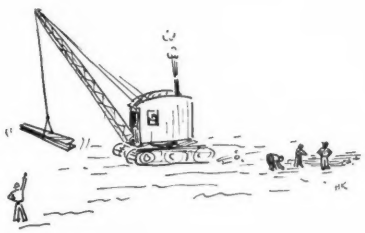
24 Mrs. Pursley promotes a spaghetti dinner for 40 customers to raise money for a nursing school project. I join the poker table afterwards where you get five chips for a cent. (Won eight cents.)

30 Monday morning having rushed past, the Rotary lunch properly dealt with, and looking forward to the generally slower tempo of the afternoon. I look over the always waiting stack of papers on my left: an insurance claim, recommendations for assigning the limited charity funds we have, a questionnaire on laundry machinery, letters to write, a fire drill to plan, a safety committee to appoint, my annual report to prepare . . which do I want to tackle first?

The telephone has a way with it. Can change all your plans once it gets you to pick up the receiver. Of course, you don't *have* to do what it says, and in this case Hugh Kneisley didn't tell me to do anything. He merely reported that a week from today they expect to have all the steel and will begin to put it up.

But that report means I had better get busy. It's fine to hear that the contractors are going to raise some steel after the public has been asking me about the empty hole for all these months. Now whom will it affect around here if they put up a few steel beams next week? Humm . . I just got those trees trimmed out of the way in time!

Went over the plans with Mr. Lewis, the general contracting fore-



man, and he explained that they had to start at the south end of the new wing because when they got through they had to be able to get out their big crane at the north end by driving it over the edge of the foundation (with a sand runway built up for it). So they were going to put horizontal beams into the existing building where rooms 326 and 226 now are. (All the while we have been expecting them to hook onto the corner where 129, 229 and 329 are located.)

Then I got the Director of Nurses and we discussed shifting patients so that we could move Dr. Wehman's office from 326. Made a temporary decision about the best place to put him and sought him out. He walked around with me and considered the limited possibilities, then agreed with me on 319. (He will also get a fine view of the Mississippi there.) So I asked Miss Beers to get the two patients out of 319 as soon as she could.

Found Miss Haveker down in her bailiwick and told her the news, including that she would have to find a place to put the patient beds and furniture in 319 as well as all the lounge furniture in 226. It will mean that patients and visitors will not have a lounge on second floor.

Ran across Roland Angier on "A" Floor and told him that there were three rooms of furniture to move within a few days, and 319 to clean up. Probably no painting to do there.

31 Told the assembled department heads at our regular Tuesday morning meeting about the steel that is supposed to go up next Monday. They are going to tear off the roof of 326, throw it down onto the floor of 326 and then throw the rubble down a wooden chute from there to a waiting truck. Next will come the outside wall of 326, then its floor, and the outside wall of 226 and its floor. There will be lots of noise and dirt when the airhammers tackle the concrete sections. Poor patients in 328 and 228.

I remember to call the telephone company and leave an order to put a phone in 319, move the one in 226 into the corridor and to remove the one in 326 only after Dr. Wehman's office has been moved into its new location, which is we don't know when, because we don't know when we will get a place to move the patients in 319. Is that clear? They were very nice, and said they would leave extension 38 in until I called and said we were ready.

Later I telephoned Cort Klein at the *Gazette* and told him that I understand they are going to start hoisting steel on Monday, and here are the details. So we leave it that I will give him a buzz if they actually get the crane going that day and it looks like there might be a good picture to take.

No telling what else will be involved before we get through with this projected steel hoisting Monday. Already it has included all these preparations, plus relocating an x-ray machine and purchasing a new microscope. And another financial effect will be the loss of two beds until the wing is completed about two years from now. That phone call last Monday was like a pebble dropped in still water with the circle of ripples spreading out in all directions. ■

Dramatizing civil defense . . is the action pictured at left in which 20 vessels "evacuated" New York City's hospitals. This operation was the curtain-raiser for the first major CD defense test in the metropolis. These craft, steaming up the East River, demonstrated how institutionalized patients could be transported via water in the event of a possible atomic attack

The ABC's of a civil defense program for average hospitals

by **Robert S. Hoyt** Administrator • Lutheran Hospital of Maryland • Baltimore, Md.

■ BEFORE GOING into the actual role of the individual hospital in a Civil Defense Program I feel that it is necessary to make some rather broad remarks concerning civil defense to try to impress upon all the important role the community hospital will play in this program. The attitude of the general public, and even Congress, towards a Civil Defense Program leaves much to be desired and makes the job of the hospital in forming a program much more difficult.

Preliminary considerations . . Have we stopped to think what would happen if one or more atom bombs, or even just plain bombs, were dropped on Washington, Baltimore or Wilmington or any other parts of these three areas? I assure you that if they were dropped tomorrow more people would be killed or injured from the resulting panic than would be killed or injured by the bombs.

Let us take a mental inventory of what each hospital has done so far to give the best possible care in the event of a major catastrophe. Are we in a position to expand our present facilities to handle eight or more times our present bed capacity, all to be admitted within a period of approximately 48 hours, and not have utter and complete confusion?

If not, then we had better get busy and make some definite and concrete plans, because if we don't and something does happen, you and I and all the others in the health field will be held responsible and this is one time we can't "buck-pass" to someone else. We, and we alone, will be responsible for the net results in our hospital and the choice between chaos and some orderly system to meet the emergency.

I am sure that we all hope and pray that the plans made to date and all plans made in the future to meet such an emergency will collect dust and never have to be used. The planning for such an emergency is like the umbrella story . . it is better to have it and not want it than it is to want it and not have it.

Plans . . Now to concrete plans. Here is what I feel each hospital should have done, be doing or start doing. First, each hospital should have a civil defense committee consisting of all major department heads such as director of nursing service, personnel director, executive housekeeper, pharmacist, radiologist, pathologist, maintenance engineer, comptroller, laundry manager, and at least one representative from the medical staff. Also there should be at least one representative of the board of directors or trustees and if there is a house staff or resident staff it should also be represented.

I also feel that this committee is important enough to be headed by the administrative head of the hospital. In the event he cannot serve in this capacity then the committee should be headed by his assistant, providing the administrator keeps himself well informed of all plans contemplated and placed in action.

Next, a drawing should be made of the building or buildings designating which areas are to be used for emergency treatment, radiation burn treatment, surgical, medical, bomb shelter for patients and personnel, sleeping quarters for personnel, an area for families of personnel and doctors (if you want a

This paper was read Nov. 26, 1951 before the Maryland-District of Columbia-Delaware Hospital Association.

large staff of personnel or doctors when an emergency takes place), morgue area, emergency laboratory facilities, information area for relatives and any other necessary areas that are needed in a major emergency. There should be several copies of these drawings. I suggest that a copy be placed on an easel at each major entrance to the hospital so that personnel and public may become familiar with the overall plan.

To do the job properly more drawings should be made because the building or buildings must be surveyed to determine how many patients can be placed in all areas allowing 40 square feet per patient, using hallways, etc. It is to our advantage to get as many as we can in our present facilities for in so doing we lessen our responsibility for satellite hospitals or emergency buildings assigned to us.

Floor plans . . Fairly accurate drawings should be made showing the present bed locations and contemplated emergency bed locations, nursing stations, utility rooms, etc. I suggest that these drawings be framed and placed on the halls that are to be used for patients so that all responsible persons may have a chance to become familiar with the arrangements and make their plans accordingly.

It is obvious that one hospital cannot handle *all* the patients that will be assigned or sent to it. This is where the emergency building or buildings assigned to use must be set up for the handling of patients and emergency treatment and even operations. The same type of plans for the emergency building or buildings should be drawn as for the permanent hospital area, showing patient areas, dietary areas, nursing stations, utility rooms, morgue, emergency rooms, etc.

In addition to this, serious thought must be given as to what we and our personnel would do if our hospital were partly or completely destroyed. There should be something definite and feasible in our plans to cover such a situation. In spite of what many think or like to believe, *it can happen here.*

A building at least ten miles out in the country from our present hospital should be procured or assigned to us for this purpose. The same type of planning should be made for this emergency facility as for the present hospital and all remaining personnel should be instructed to report to this location in the event of such a catastrophe.

We are told there will be transportation organization. At present there seem to be only plans to "ride" on, so in the event of a transfer to another location it may well be "every man for himself"! It is hoped that a division of civil defense, either national, local or both, will stockpile for distribution furniture, linens, equipment and supplies to expand present facilities and/or to operate emergency facilities.

Table of organization . . It is obvious to all of us that present personnel cannot adequately man such a set-up. Therefore it is necessary that we all rely on voluntary personnel, some trained, some partly trained and some untrained. We should plan to use such personnel to the best advantage. There is only one way to do this effectively and that is to set up a table of organization, spreading trained personnel as thinly as possible and using voluntary help to the utmost to give patients the best possible care under such an emergency.

It is suggested that teams be formed, such as surgical teams, burn teams (if we can get surgeons to agree on what treatment to use), etc. As soon as it is possible to obtain clearance or confirmation of personnel assigned to an individual hospital, a training program should be established and teams formed, with each team being assigned definite duties.

It is most important that medical personnel be trained to send all present ambulatory and least ill patients home or to the nearest shelter, and place those who cannot be sent home in a previously designated area.

Any and all plans that are made now may not actually work in reality but at least some thought has been given which may lessen the chaos. Another suggestion that can be made to prevent confusion is that a traffic plan be made and given to civil defense officials in your area as to routing ambulances to certain entrances, supplies to another, information concerning patients to another, personnel to yet another designated entrance and so forth. This could help a great deal in preventing external confusion.

Family area . . I mentioned before the possibility of designating an area for families of personnel. I do not believe this can be emphasized enough. It is the first thought of all to protect our families and if we can make such an arrangement our personnel and doctors will be greatly relieved and be available to us that much more quickly.

In making our plans there are two other items that should be given considerable thought and they have not been mentioned to any great extent in any part of civil defense planning. The first: the possibility of more than one bomb being dropped on a given location the following day or on a series of days or weeks. Our plans should include coverage for a *series* of emergencies.

The other item is the possibility of internal sabotage which might flood a hospital with 50 to 100 emergencies at one time and still not be sufficient to use a master civil defense plan. Therefore our planning should include a phase which could be placed in effect immediately to cover an emergency of this type.

By now you have noticed that I have not mentioned supplies at all. This is because there is little to say about this subject at present. Few hospitals have sufficient cash to increase their inventory and if they did there never is sufficient storage for normal supplies, much less more, and in the event a hospital had cash and space the very items we need to stock are in short supply for normal use today.

Plans and training programs can be worthless unless tested in an imaginary emergency to detect flaws and shortcomings. Therefore a "dry run" should be made by our organization. None of us should underestimate the gravity of situations we may be called upon to handle. It is better that we find ourselves with a surplus of preparedness, if such is possible, then to be caught with too little, too late. ■

Judging the adequacy of psychiatric aides

A study of psychological factors that contrast the most and least efficient psychiatric aides in a mental hospital

by Joseph John Vaccaro, Ph.D. Chief, Clinical Psychology Section
Neuropsychiatric Service • U.S. Army Hospital
Camp Atterbury, Indiana

■ THE NEED for a better understanding of the psychiatric aide has long been recognized. Psychiatric aides have a function of caring not only for the physical needs of mentally disturbed patients, but also of participating in a program of therapy. The presence of inefficient or inadequate psychiatric aides places a great burden on the neuropsychiatric institutions. Inefficient aides are costly in terms of money, energy, supervision and replacement. (It has been estimated, for example, that it costs the United States Government $300 when the turnover of one psychiatric aide is involved.) However, of even greater importance is the fact that the inefficient aide is not only unable to participate adequately in a therapeutic program, but he may actually be instrumental in hindering the recovery of the patient.

The past few years have seen a shift in emphasis in the attendant problem from one of recruitment to one of selection. Until recently funds for this type of personnel were so limited that salaries ranging from $45 to $60 per month were paid. The personnel attracted by these salaries were sometimes sick themselves or were very inadequate individuals and hardly able to do a job of maintenance. More recently salaries have been substantially increased (the Veterans Administration being one of the forerunners in this respect), so that now in most geographic areas adequate numbers of personnel are available and the problem has become one of differentiating the potentially good from the potentially poor psychiatric attendant.

In spite of the fact that the attendant problem has been a source of difficulty to most institutions, few studies have been made with this type of personnel. The few that have been made with psychiatric aides as subjects have been limited to the study of relationships in restricted areas of personality, or have been devoted to the setting up of a selective device. Other psychological studies employed psychiatric aides as controls in investigations of pathological groups.

Quadruple aims . . The investigation which constitutes the basis of this paper was undertaken to study the psychological factors that contrast the most and least efficient psychiatric aides at the Lyons Veterans Administration Hospital. More specifically, the aims of the investigation were: (1) to determine from a battery of psychological tests the differences that may exist between two groups of psychiatric aides, one of which is "most efficient" and the other "least efficient"; (2) to determine whether there is any difference in the personal data obtained from members of the two groups; (3) to determine whether the variables which give significant inter-group differences also yield different intra-group relationships when studied separately for the two groups in reference to other test variables; (4) to determine whether there are any characteristics in such an attendant population which should be considered when they are used as controls in psychological investigations.

These objectives called for the rating of the entire psychiatric aide population at the Lyons Veterans Administration Hospital to obtain the "best" ten per cent and the "poorest" ten per cent of this sample. These extremes in terms of efficiency were chosen in order to maximize existing differences, and to facilitate the task of rating.

Determination of aide ratings . . In order to avoid possible bias due to length of employment, the length of service of the individuals who were to make up the experimental samples was controlled. In addition, those aides employed less than five months at the hospital were excluded since it was felt that this period of time was necessary for the supervisors to become acquainted with the aides' work. The ratings were made by three individuals who had the best over-all picture of the aides at the institution, namely, the chief of the nursing service, the supervisor of aides and the chief aide.

The rating procedure was divided into two parts: (1) The first phase rating, which was an over-all evaluation of the entire hospital aide population, and (2) The second phase rating, which was a more detailed evaluation of the extreme groups chosen in the former phase. The first phase rating involved the distribution of the hospital aides (473 in all) into three categories, namely, poor, average and good. It was desired to have approximately 80 of the best aides fall in the good group and 80 of the poorest aides in the poor group.

An abstract of a dissertation submitted in partial fulfillment of the requirements for the degree of doctor of philosophy in the department of psychology at Fordham University.

Although only 50 individuals were desired for the final experimental samples, the larger number was necessary so that there would be a reservoir of aides should some be dismissed, resign or be lost for some other reason. Each rater was accordingly given as a guide a table showing the expected distribution into each of the three categories.

Those aides who fell into the poor and good categories as a result of the agreement of the raters were then evaluated further in the second phase rating. In this phase those aides who fell in these extreme categories were rated in seven job performance areas on a five-point scale. The rating scale used was a modification of that employed in a study of hospital attendants by Central Office, Veterans Administration.

When the aides had been assessed in the second phase of the rating procedure, the evaluations of the three raters were combined so that an over-all rating was obtained for each of the aides who fell into the extreme categories. On the basis of these latter over-all ratings the aides were then ranked so that the best fifty of the good group and the poorest fifty of the poor group were obtained. These groups made up the two experimental samples.

In order to determine whether the agreement of the raters was better than that expected by chance a chi-square test of significance was applied to each of the two rating phases. The results obtained indicated that on the over-all evaluations in each of the two rating phases, the agreement between the raters was significant at the one per cent level of confidence.

Once the two experimental samples were established, a battery of psychological tests was administered. These aide groups were also asked to fill out personal data sheets for background information. Usually three sessions of approximately one hour and one-half each were required to administer the tests and questionnaire.

Tests used . . The following tests were administered to these groups:

(1) *The Otis Self-Administering Test of Mental Ability* was administered to obtain a measure of mental ability. The Intermediate Form of this test was used because the Higher Examination was considered too difficult for the over-all group.

(2) *The Oral Directions Test* also yields an index of mental ability. This test was administered because it involves the carrying out of verbal directions, which the aide is constantly called upon to do, and because it was desired to observe how the aides performed on less formalized types of examination such as this. It was considered that a written intelligence test might penalize a group such as the psychiatric aides, many of whom had little academic training and most of whom had been away from formalized examinations for a long time.

Q. . When is an aide not an aid?
A. . When he is a hindrance to the recovery of the patient and a costly factor to hospital administration because of inefficiency and frequent replacement.
Q. . How can you tell when an aide **is** an aid?
A. . This article explains in detail.

(3) *The California Occupational Interest Inventory* reveals the occupational interests of the groups. This test also lends itself to a pattern of interest for each of the sexes. Since a feminine pattern has long been suspected in the psychiatric aide, a comparison of the scores obtained by the aide groups with the feminine pattern of interest was deemed of value.

(4) *Terman-Miles Attitude-Interest Analysis Test* was used to determine whether the aide groups' emotional attitudes were more masculine or more feminine.

(5) *The California Mental Health Analysis Test* was administered in order to obtain a measure of the personality adjustment of the aides. This knowledge becomes important in the case of psychiatric aides since they are constantly in contact with extremely maladjusted and psychotic patients.

(6) *The Picture-Frustration Study* was employed in order to determine the way the psychiatric aides react to frustrating situations. A knowledge of the aides' reactions is important because if there should be an externalization of aggression the object of such aggression might well be the patient.

The findings of the investigation may be summarized thus:

Contrast of psychiatric aides and general population . . (a) Both aide groups manifested significantly less mental ability than the average, the better group deviating less than the poorer.

(b) The aides had significantly more interest than the average person in occupations dealing with rendering service to others, and in activities involving verbal communications.

(c) Significantly less than average interest was found in scientific and mechanical fields.

(d) Better than average personality adjustment, as measured by the tests, was found in both aide groups.

(e) The aides manifested a more feminine occupational interest pattern, but more masculine emotional attitudes than the average. It was suggested that this apparent discrepancy may be due to the fact that occupational interests are more superficial and as such easily changed by employment as an aide, whereas emotional attitudes are more basic to the personality structure and withstand change.

(f) It was likewise observed that the aides tend to direct aggression toward the environment to a lesser degree than the general population.

The manner in which the aides parallel each other in contrast to the general population in the above areas, is suggestive of factors common to the aides as a whole. It seems important, therefore, to consider such factors when the aides are used as normal controls in psychological studies.

Contrast of the two aide groups . . The two groups were first compared by means of tests to obtain the following results:

(a) *Mental ability tests . .* Both mental ability tests yielded significant differences between the two groups of aides, the Otis differentiating the two groups at the five per cent level of confidence, and the Oral Directions Test at the one per cent level. With both tests, the efficient aide was significantly more intelligent than the poor aide, indicating the importance of this factor in aide efficiency.

(b) *Personality test* . . The Total Personality Score, which is an overall measure of personality adjustment, freedom from Liabilities and freedom from Feelings of Inadequacy, differentiated the two groups at the one per cent level of confidence, while Behavioral Immaturity, Emotional Instability, and Physical Defects differentiated them at the five per cent level.

In addition, the better aide group tended to superiority both in ability to form close relationships with others, and in satisfaction with work and recreational activities. All the areas which significantly differentiated the two groups showed the most efficient group of aides to be better adjusted than the least efficient group.

(c) *Interest test* . . Although none of the occupational interest areas significantly differentiated the two aide groups, there was a tendency for the good group to manifest greater interest toward occupations which render service to others, and less interest in occupations dealing with mechanical things.

(d) *Emotional Attitudes test* . . In the area of emotional attitudes, the two groups of aides are differentiated significantly, the better group manifesting the more masculine direction.

(e) *Frustration Reactions test* . . In terms of reactions to frustrating situations it was found that the better group of aides, to a significantly greater degree than the other extreme group, directed blame or censure on themselves rather than on the environment. This internalization of aggression is considered a desirable trait among aides, since the patient could readily become the object of external aggression.

Results . . With respect to Background Information, the following results were obtained: (a) Of all the background factors studied only education was able to differentiate the two aide groups significantly, the better aide group having approximately one more year of schooling. (b) Certain rather clear trends were, however, observed in the contrast of the two aide groups with respect to age, marital adjustment and military service.

On the basis of the above findings the following picture emerges of the efficient aide, as contrasted with the inefficient aide. He is approximately two years younger than the inefficient aide; he has reached approximately the eleventh grade in school and has an intelligence quotient of about 97. Although the good aide is below the average in general intelligence, he is, nevertheless, significantly more intelligent than the poor aide. There is a tendency for the efficient aide to be better adjusted maritally. It is also likely that he has seen military service and that he is native born.

He is an individual whose personality adjustment is better than average, since he manifests emotional stability, behavioral maturity, and feelings of self-confidence. His work and recreational activities tend to be satisfying to him in contrast to the poor aide, and there is a tendency for him to be able to form close relationships with others. His occupational preferences involve dealing with people rather than objects. His pattern of interests tend to be more feminine, but his emotional attitudes, which may be a more basic part of his personality, are more masculine, when compared both with the poor aide and with the general population. In reacting to situations involving frustrations, he would rather direct the aggression upon himself by self-blame or censure, than externalize it.

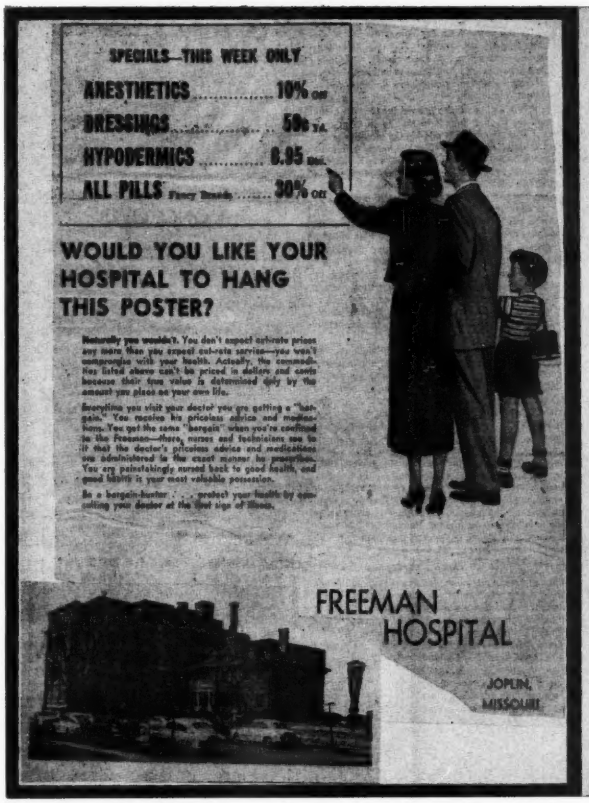
Intra-group variables . . (a) The most important finding in this section was that the test variables correlated better with the criterion (efficiency on the job) in the case of the good group than with the poor group. All of the significant correlations with the criterion were found in the good group, none with the poor group.

(b) These findings suggest that in terms of selection, it might be a more promising and successful procedure to attempt to select the better aide by raising the cut-off point, rather than by concentrating on elimination of the poorer aide with a lower cut-off point. This procedure is contrary to usual practice in the past where emphasis has been directed to excluding the poorer aides.

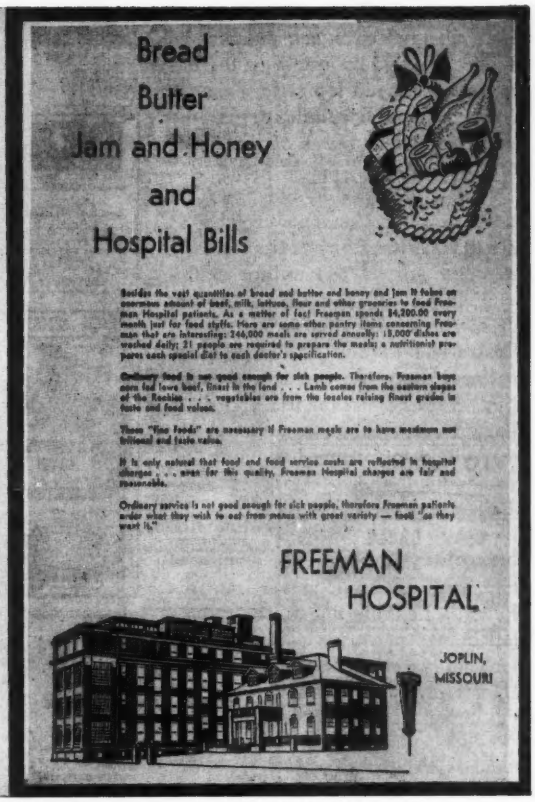
With the present trend in psychiatric thinking toward aide participation in the neuropsychiatric team set-up, the attempt to select the better aides would seem more justified than merely to eliminate the poorer ones. If a place of responsibility is to be given to the aides on the psychiatric team, it is essential that these individuals be capable of assuming such responsibility. The suggestion is made of the possibility of establishing two levels of aides, namely, a psychiatric aide and an assistant psychiatric aide.

The psychiatric aide might be a better aide for whom the qualifications would be higher. In consequence, it might reasonably be expected that he could assume greater responsibility, would be more sensitive to unusual behavior in the patient, and would adequately handle situations which constantly arise. At the same time he could take a more active part in the patient's rehabilitation by following more rigidly the goals set up by the psychiatric team. The assistant aide could play a subsidiary role which would be oriented more toward the physical care of the patient. On the basis of the results of this study, it would appear that the psychiatric aide could be significantly differentiated from the assistant psychiatric aide on the basis of proficiency and test performance.* ■

*If it were desired to employ, in terms of prediction, the tests used in this investigation, the preferred order of the tests would be as follows: Both tests of mental ability might be used but the Oral Directions Test is better because it differentiated the two groups more significantly and because it is a more suitable test where lower mental ability is concerned. The California Mental Health Analysis and the Terman-Miles tests also differentiated the two groups significantly. On the basis of the results of the present study, the Picture Frustration Study and the California Occupational Interest Inventory do not seem very promising as predictive devices since the former was able to differentiate the two groups in only one area, and the latter merely indicated trends.


SPECIALS—THIS WEEK ONLY
ANESTHETICS ..... 10% off
DRESSINGS ..... 50c ea.
HYPODERMICS ..... 6.95 doz.
ALL PILLS Fancy Brands ..... 30% off
WOULD YOU LIKE YOUR HOSPITAL TO HANG THIS POSTER?
Naturally you wouldn't. You don't expect private prices any more than you expect cut-rate service—you won't compromise with your health. Actually, the commodities listed above can't be priced in dollars and cents because their true value is determined only by the amount you place on your own life.
Everytime you visit your doctor you are getting a "bargain." You receive his priceless advice and medications. You get the same "bargain" when you're confined to the Freeman—there, nurses and technicians see to it that the doctor's priceless advice and medications are administered in the exact manner he prescribes. You are painstakingly nursed back to good health, and good health is your most valuable possession.
Be a bargain-hunter . . . protect your health by consulting your doctor at the first sign of illness.
FREEMAN HOSPITAL
JOPLIN, MISSOURI

The above advertisement . . ridicules the idea of "bargains" as far as hospital care and its cost are concerned


Bread
Butter
Jam and Honey
and
Hospital Bills
Besides the vast quantities of bread and butter and honey and jam it takes an enormous amount of beef, milk, lettuce, flour and other groceries to feed Freeman Hospital patients. As a matter of fact Freeman spends $4,200.00 every month just for food stuffs. Here are some other pantry items concerning Freeman that are interesting: 246,000 meals are served annually; 18,000 dishes are washed daily; 21 people are required to prepare the meals; a nutritionist prepares each special diet to each doctor's specification.
Ordinary food is not good enough for sick people. Therefore, Freeman buys corn fed Iowa beef, finest in the land . . . Lamb comes from the eastern slopes of the Rockies . . . vegetables are from the locales raising finest grades in taste and food values.
These "fine foods" are necessary if Freeman meals are to have maximum nutritional and taste value.
It is only natural that food and food service costs are reflected in hospital charges . . . even for this quality, Freeman Hospital charges are fair and reasonable.
Ordinary service is not good enough for sick people, therefore Freeman patients order what they wish to eat from menus with great variety — food "as they want it."
FREEMAN HOSPITAL
JOPLIN, MISSOURI

This ad . . conveys a good deal of information about the operation of the hospital . . with emphasis upon quality

These ads built good will

by F. James Doyle

■ WHEN ADVERTISEMENTS for hospitals are mentioned, the thought naturally arises, "But are they ethical?" And a corollary might be, "If they *are* ethical, what kind is best?"

These questions are answered by the examples shown here. All three appeared . . at the rate of one a month . . in the *Joplin Globe* of Joplin, Missouri, as parts of a 12-time schedule. They are the work of Harry D. Keller, administrator of Freeman Hospital in Joplin, who wrote the copy, selected the illustrations and provided the layout.

Some of the series were written while Mr. Keller was administrator of the Grand Forks Deaconess Hospital, Grand Forks, N.D., while the rest were originated to fit the Joplin area and the needs of Freeman Hospital.

Ethics . . It is true that the ethics of advertising for the medical profession . . or any allied facility providing medical care . . are involved. A traditional "code" precludes competitive bidding, blatant claims and other standard advertising techniques . . so far as the physician and surgeon are concerned. By association, many hospital administrators even today experience a vague unease at the conjunction of ideas implied in "advertising for hospitals."

Nevertheless, proper and productive public relations almost necessitates a cogent program presenting the hospital's problems to its community. The multitudinous complexities and dilemmas that confront or impede the operation of the institution should, in all justice, be brought to the attention of those who use and support it. There is no doubt that it is "ethical" to do so.

What ad is best? . . In this day of high-powered promotion of everything from pins to Packards, there remains something else for the administrator or public relations director to consider: What kind of advertisement is best? The answer . . in simplest terms . . seems to be that advertisement which is conceived for, attuned to and directed at the locality.

"Canned" advertising applicable to practically any place in the United States has its uses . . it is better than no publicity at all. However, really effective lines of communication are best achieved at the "grass roots" level, as these illustrations attest.

No amount of generalization about rising hospital costs can possibly be as effective and adequate as the argument displayed top right, page 49, which relates hospital service directly to and in terms of the needs of its environs.

No less striking is the fact that such an advertisement can be as attention-getting as commercially prepared ads, if the author shows originality with a fresh approach. (Note the prevocative heads on the illustrations.) The headings, illustrations† and the relatively short copy . . plus a liberal use of "white space"* . . combine to make an effective and rewarding impact on the readership *that matters to the hospital.*

Exemplary copy . . Since most of the text of the advertisements shown is illegible due to the reduction in size necessary for reproduction, let us quote the text of one advertisement to indicate their general tenor. We read in Figure 2:

Besides the vast quantities of bread and butter and honey and jam it takes an enormous amount of beef, milk, lettuce, flour and other groceries to feed Freeman Hospital patients. As a matter of fact Freeman spends $4,200.00 every month just for food stuffs. Here are some other pantry items concerning Freeman that are interesting: 246,000 meals are served annually; 15,000 dishes are washed daily; 21 people are required to prepare the meals; a nutritionist prepares each special diet to each doctor's specification.

Ordinary food is not good enough for sick people. Therefore, Freeman buys corn fed Iowa beef, finest in the land. . . Lamb comes from the eastern slopes of the Rockies . . . vegetables are from the locales raising finest grades in taste and food values.

These "fine foods" are necessary if Freeman meals are to have maximum nutritional and taste value.

It is only natural that food and food service costs are reflected in hospital charges . . . even for this quality, Freeman Hospital charges are fair and reasonable.

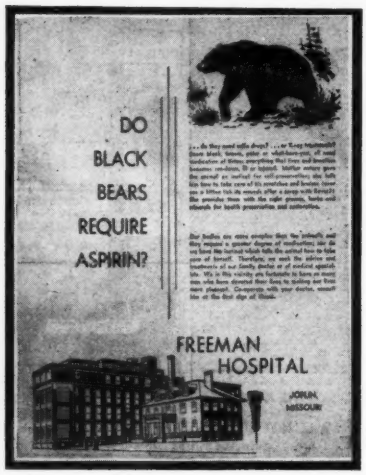
†Note, with regard to the illustrations, how much better the black-and-white line cut of the hospital shows up in Figures 2 and 3 than the half-tone in Figure 1, which was too fine to reproduce well on the coarse newsprint.

*"White space," i.e., an area in an advertisement devoid of either illustration or text, is unusual in most ads produced by non-professionals, since the amateur ordinarily wants to crowd as much as possible into the smallest possible space.

Ordinary service is not good enough for sick people, therefore Freeman patients order what they wish to eat from menus with great variety — food "as they want it."

Public reaction . . to these advertisements has been gratifying.

"Reaction to the series," says Mr. Keller, "has been beyond our fondest expectation, reaching particularly well the business men of the area to whom advertising is an item that makes sense. The reaction of the



This catchy question . . practically demands readership from the members of the community whom the hospital is endeavoring to reach and influence favorably

business men who advertise has been so gracious as to cause us to think in terms of a twice-monthly series rather than the monthly one planned.

"The public generally has been talking about the ads, too . . which in itself is a public relations success in very gratifying terms."

Thus the fears of administrators that advertising might be regarded by the community as "money wasted" or as "undignified," are allayed by the result.

Summary . . On the basis of the visual evidence presented here and the conclusions reported by Mr. Keller, it can be said that ads . . especially copy . . built at the "grass roots" level, and directed to a particular target by a creative, acute hospital executive, are not only ethical but most valuable components of a public relations program. ■

Fatal gas blast during operation unexplained

■ THE DANGERS of gas explosions during operations were pointed up again in dramatic fashion Feb. 4 at St. Francis Hospital, Evanston, Ill., when a priest, Rev. James Cummings, 35, died after an explosion in the anesthetic equipment while he was on the operating table. The inquest failed to assign a cause for the blast.

Although percentagewise these unfortunate occurrences do not loom large yet they serve to point up the need for every precaution. Because of their dramatic nature they invariably get wide attention in the press with a resultant adverse effect as far as the public relations of all hospitals are concerned.

The National Fire Protection Association, through its committee on hospital operating rooms and its committee on gases, some nine months ago set up a code of safe hospital operating room practices which should be a part of the library of every hospital and every hospital consultant and architect. The section devoted to safe operating room practice begins on page 105 of the 1951 edition of "Hospital Fire Safety." Its price is $2.00 and it can be had from the National Fire Protection Association, 60 Batterymarch Street, Boston 10, Mass.

Hospital Council disputes charge

■ THE CINCINNATI Hospital Superintendents' Council took sharp issue recently with a charge in a DeCourcy Clinic staff bulletin that "dictation by the hospital or any other group of physicians" in connection with the length of a patient's hospitalization period "constitutes a step in the direction of socialized medicine."

Staff of the DeCourcy Clinic, Cincinnati, is headed by Drs. Joseph L. DeCourcy and Cornelius B. DeCourcy.

Hospital teaching . . should offer variety, says Mrs. Carroll, shown with two pupils

Bringing the three R's to young patients

by Aline Hughes Public Relations Director • St. Luke's Hospital • N.Y.C.

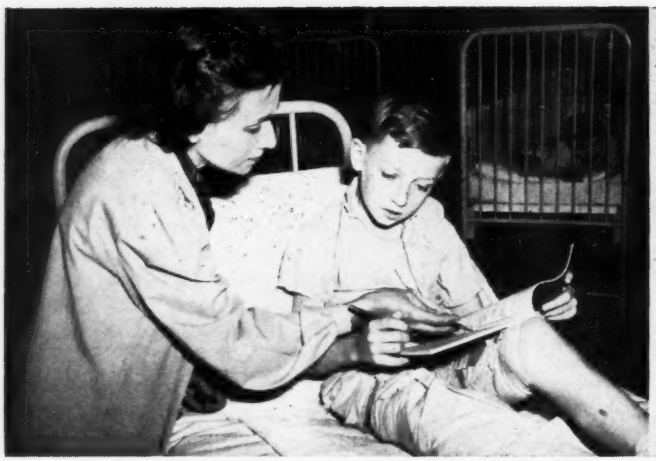
Lower left . . Child reading on the sun porch of St. Luke's Convalescent Hospital

■ LIKE HER COUNTERPART in the little red school house, Mrs. Violet Carroll teaches all elementary grade subjects in her work as a full-time public school teacher at St. Luke's Hospital, New York. The same is true in the part-time work of Mrs. Sylvia Shainin with high school subjects, and of Miss Louise Dalgleish at the St. Luke's Convalescent Hospital. This activity is a part of the program of the Board of Education of the City of New York. Teachers are assigned at the request of the individual hospital, which must have a permanent registry of at least ten children.

St. Luke's was one of the first hospitals in New York to realize the value of a teacher for children with long-term illnesses, and this work was supported by the hospital from voluntary contributions for more than 50 years. In 1935, however, a public school teacher was assigned by the city at the request of the hospital.

The arrangement has proved to be a very satisfactory one, enabling the young patient to keep in touch with his school work and to receive credit for it. This is often a real relief from worry to the conscientious girl or boy.

Attitudes differ . . "I'm not always welcome at first," Mrs. Carroll reports. "Children often are relieved at the thought that they will escape school work when they come to the



A young arithmetician . . puzzles seriously over a problem in his work book, under the tutelage of Mrs. Carroll

An appealing student . . keeps up her high school work with Mrs. Shainin's help

hospital, so they sometimes feel resentful when I appear."

Mrs. Carroll, however, is adept at winning their interest without forcing herself upon them.

"I guess my size helps," she says. "The fact that I'm not very tall as I stand beside their beds seems to set them at their ease."

When it is possible to work with an interested child near the one who doesn't want help, she finds that the latter soon realizes he is missing a chance to get private assistance on problems which have troubled him. He understands very well his own lacks and weaknesses in school, and eventually he seeks help from her.

Sometimes a jigsaw puzzle or a picture book will pave the way for her, or even one page from a loose-leaf arithmetic book. Once she has whetted his interest, and when he feels stronger, she can continue with the regular course. Each child has his or her own work book.

Special problems . . Teaching sick children has problems of its own. They are often in pain and lacking in strength. Hospital routines take up a great deal of time . . tests, medications, dressings, the regular "rounds" of pediatricians and other doctors who may be involved in the child's treatment.

Many of the children are in plaster casts; some may have to lie on their stomachs in body casts. They may have a leg or arm suspended in traction. Perhaps they are cardiac cases whose activity has to be apportioned over a number of short sessions. For this work one needs a sensitive, gentle but firm approach, in order to interest the child in something outside his illness, while not overtaxing his strength.

The territory to be covered by the high school teacher is more definite perhaps than that with the elementary grades, and often includes preparation for the State Regents examinations. Once or twice, young patients have completed elementary or high school work while in the hospital. In each case a little graduation ceremony was arranged, with the child's own school teacher presenting the diploma in the presence of parents, other young patients and members of the hospital staff.

With younger children, the teacher is more interested in keeping them in touch with the everyday world and helping them not to forget what they had already learned in school. The little ones learn to count and to recognize colors as they string beads or take part in other activities suited to their age. Sometimes a special kind of spelling bee, which includes simple information, will occupy the minds of young patients who must lie very still.

Teamwork helps . . Doctors, nurses, and social service workers are the team who assist the teacher in knowing the child's needs and strength, as well as his emotional and family problems. One child with severe mastoid conditions, who was terrified of people in white because she had suffered so much pain which was associated with doctors and nurses, welcomed Mrs. Carroll's blue smock and was sometimes allowed to have her lesson in the teacher's nearby office. This comforted her greatly.

The completion of simple handwork was helpful to a small boy emotionally disturbed by family conditions. This seemed to give him self-confidence. In fact, handwork which absorbs the interest of the young patient is of great value. In this work Mrs. Carroll has had the collaboration of an art teacher who is one of the hospital's volunteers. Other volunteers bring music and story-telling at regular times in the hospital's over-all plan for recreation, occupation and instruction.

One young girl recently kept up with her school class while she was undergoing a series of spinal operations. Her teacher and classmates kept her in touch with their projects and the hospital teacher helped her to continue her work with them from a distance. It gave satisfaction to all concerned, carrying out as it did the twofold purpose of the teaching program, which is to prevent the child's losing too much time from school work through illness, and also to occupy and interest the young patient with a view to leading him gently back into everyday healthy life. ■

How hospital service benefits rural patients and how to educate them to use it

by **E. M. Collier, F.A.C.H.A.** • Administrator • Hendrick Memorial Hospital • Abilene, Texas

■ THE SUCCESS of a hospital program to fill the needs of rural people is definitely dependent upon a vital educational program. In the past it has been difficult to sell hospital services to rural people. Too many have assumed that country life and good health are synonymous.

Surveys showed that rejections for service in the Armed Forces were higher among rural people than other groups. Selective Service shows that 4% more white rural boys than city boys were rejected in the draft on physical grounds alone. For Negroes, 7% more rural than city boys were rejected and the death rate in rural areas is higher in all age groups than in urban areas.

This has shocked rural people out of their complacency. We must change our attitude in thinking of the hospital as a place one goes to as a last resort . . a place where one goes to die. We must learn to look upon a hospital as a health center and on the doctor as the man who is hired to keep us well instead of a person to go to only after all home remedies and patent medicines have failed.

Our rural people must learn that epidemics of measles, smallpox, whooping cough or scarlet fever are not necessary evils that all children must endure, but that they are preventable and that serious complications can develop from these recurrent epidemics. A vital educational program will make people health conscious and play a definite part in developing community participation in supplying community health needs.

Farm families get less hospital care even in normal times. The admission rate in large cities is about 60% higher than for rural areas, and more than twice as many disabling illnesses are hospitalized among urban residents as among rural families. Hospitalization experience is far lower in rural areas when measured by the number of cases per 1,000 population per year or by the total number of hospital days per 1,000 population per year. Thus, in cities of 100,000 or more studies have shown that there are 67.5 hospital cases per 1,000 population per year in comparison with 42.0 in rural areas. In cities of 100,000 or more there are 858 days spent in the hospital per 1,000 per year in comparison with 595 in rural areas.

Whatever index is used, the rural health experience for hospital care as well as for physician's services and for surgery and specialist care tends to be lower. This is borne out not only by comparison of the total rural and urban population but also by comparison of the same income group, which shows that rural experience is lower.

Needs . . The American Farm Bureau has established a committee that is engaged in the study of the problem of rural health. There are in many states similiar committees created for the purpose of cooperating with the national committee. The latter has met with the respective committee of the American Medical Association and during the discussion it was informally agreed that the existing needs include:

1. A constructive program for medical services on a voluntary basis.
2. Local participation in and control of such programs.
3. Medical services in rural areas based on sufficient income for and availability of facilities to the rural doctor.
4. Attack on the whole health problem of preventative as well as curative medicine on a basis broad enough to service the entire rural population.
5. An evolutionary, but not a revolutionary, program.
6. An adequate survey of health needs.
7. A plan to assist in providing scholarships or loan funds for worthy rural youth to make possible their study of medicine, with or without their agreement to return to the country for practice.
8. The development of pre-payment medical and hospital care on a sound actuarial basis without subsidy.

The above eight points offer a practical plan to think about and work for the solution of rural medical problems.

The economic base . . Now we come to the very core of the problem of providing for rural health services. Is there ample wealth today in the average rural area for the establishment of adequate health services? The answer would appear to be in the affirmative. There are many exceptions but the idea that farm areas must be pauperized should be discarded. *The answer*

This paper was read Feb. 4, 1952 at the sectional hospital conference of the American College of Surgeons at Dallas, Texas.

to rural health problems does not lie in socialization.

We have assumed for so long that there was no great amount of wealth in rural communities and the farmers have had, in past years, perforce to guard their profits and savings with such extreme care against the lean years that the idea of financing the small rural hospital locally upon a liberal basis will probably come as a shock even to many rural residents. However, it can be done. That is not to say that all the funds should be raised locally, since, even if possible, this is not always desirable.

It is necessary to think in concrete and simple terms to grasp this new fact of a changed economic base for rural health expenditures. As good figures as any to illustrate our bettered position are those on national farm income.

From 1799 to 1917 there was a steadily rising curve of agricultural income, reaching in the latter year about 9.6 billions of dollars. For three years thereafter there were war-boom times, with marked increase in farm income, which declined in 1921 to more than the 1916 level but less than that of 1917, with income very slowly rising until a peak of almost the 1917 level was reached in 1925.

There then developed an ominous change, for the curve of farm income turned slowly but irresistibly downward for the years 1926 to 1930, after which this decline proceeded at an accelerated pace. In 1932, national dollar agricultural income declined to less than that in 1901!

Immediately thereafter, however, the cycle turned upwards. By 1939 it was almost double the 1933 figure. By 1943 it had much more than doubled again! By 1948 it was more than six times the figure in 1933!

Persuasion . . This wealth must be tapped by persuasion, not conscription; by universal consent, even to local taxation. The nonprofit hospital is a community venture that needs the support of all. The government hospital may be a necessity in certain improverished areas and for such special purposes as the care of veterans, the tuberculous, and the mentally afflicted, but government-dominated hospitals do not belong in the average rural community.

So much has been written on this subject that if printer's ink were adequate to the solution of the problem it should have largely disappeared by now. Unfortunately, it takes more than a beautiful set of architectural floor plans to erect and maintain a rural hospital.

The idea has been entertained by some theoreticians that one can satisfy the need for rural hospitalization by 6-bed, 10-bed, and 15-bed rural hospitals and health centers. This may have some application at trading posts along the Arctic Circle, or at the headwaters of a tropical river, but is scarcely acceptable to Americans of this day and age.

The trend has been steadily against the less-than-50-bed hospital and steadily in favor of larger hospitals. The technologic and financial reasons are too obvious to require discussion. One of the reasons for the failure of rural small hospitals to increase in number has been the failure of rural communities to plan independently and thoughtfully for the professional and financial success of such hospitals. A plan to erect something that will provide only the bare necessities of medical service from a minimum of funds is doomed to failure. The crux of each rural problem is the extent of the need, not the cost.

Transportation . . The increasing speed of transportation has, of course, rendered less necessary the scattering of small hospitals throughout the country. Good roads, community ambulances, fast trains and even faster planes have brought the big city hospital relatively much nearer to the average rural community and this has tended to dampen enthusiasm for those sacrifices necessary to the building of a small community hospital.

A few years ago you could find a small school house at every cross road in the country. They were poorly equipped and under-staffed and did a very poor job as far as education of rural youth were concerned. We have seen these improvised schools fade away and the consolidated school come into being. Our rural people have found it is much better to have one large school serving a large area than to have a number of small schools in the community. The lesson learned about the schools should apply to building a hospital. We should not encourage the building of too many small hospitals and we should do a better job educating our rural people to drive a few miles over a good road to get to a well-equipped and staffed hospital.

Indigent care . . Poor health is not only a disgrace to the community, it is a danger to the health of the entire community. No matter how much may be paid out by part of the members of that community for good health care, the care of the medically indigent is an acute problem in most counties. The county government should provide ample funds to hospitalize all the sick and injured indigent cases in an approved hospital, and pay at least the cost of such care.

Two things will solve most of our rural health and hospital problems in most states:

1. Blue Cross and Blue Shield.
2. County aid for the indigent patient. ■

N.Y. health, welfare agencies merge

■ MERGER of the Welfare Council of New York City and the Health Council of Greater New York has been agreed upon, with formal approval by the Greater New York Fund, which supports a number of the constituent members of both organizations.

The new combined agency is to be known as the Welfare and Health Council of New York and is expected to be a more economical and effective unit for meeting the city's health and welfare needs. Raymond Hilliard, former New York City commissioner of welfare and executive director of the Welfare Council, continues as director of the new organization.

According to Frederick W. Gehle, executive director of the Greater New York Fund, the 1952 budget for the combined agencies will be a little in excess of $400,000. ■

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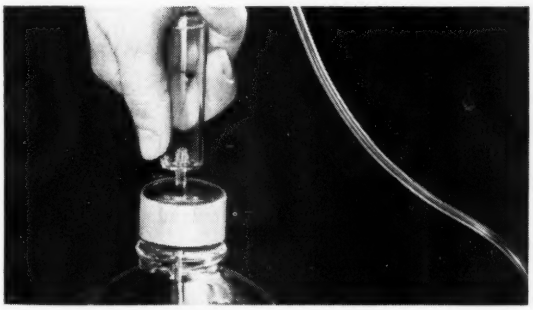
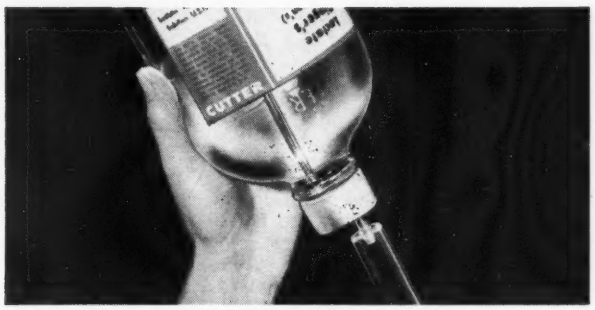
Scanning Time 19 Seconds

The Saftitab* Stopper is the only *one-piece* stopper. It is standard on both Cutter Saftiflask® Solutions and Blood Bottles—just one technic on both. Molded-in tabs easily removed from "air" and "outlet" openings. No extra diaphragm or liner to remove.

FOR SAFETY

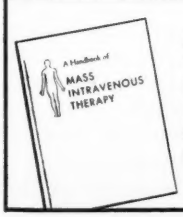


Saftiset*, the only all-plastic, breakage resistant expendable I. V. set, simplifies infusion. It is sterile and ready for immediate use.



Sealed under vacuum, Cutter Saftiflask Solutions are safe, sterile, pyrogen-free. The large label can be easily read in any position.

WITH CUTTER



For your complimentary copies of a handbook "Mass Intravenous Therapy," see your Cutter hospital supplier.

Eye Opener Watch the next Cutter Saftisystem demonstration in your hospital.

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CUTTER LABORATORIES, BERKELEY, CALIFORNIA **Cutter Trade Mark*

news of voluntary health plans

conducted by Virginia M. Liebeler

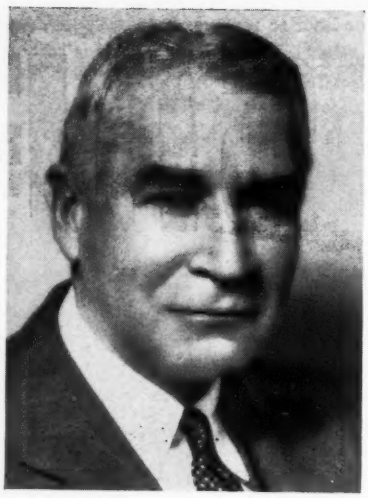
Louis H. Pink — humanitarian

■ HATS OFF to a gentleman, a scholar, a businessman, an indefatigable humanitarian, a human dynamo all rolled into one. Who? Why Louis H. Pink, of course. For who but an idealist and a realist like Mr. Pink, chairman of the board of Associated Hospital Service of New York and an active worker in 15 other organizations, would undertake the chairmanship of the Greater New York Chapter of the National Foundation of Infantile Paralysis? A task that will take plenty of time and energy, for the job entails the coordination and supervision of all campaign activities. But Mr. Pink was never afraid of work.

His decision to enter the fight against polio is typical of the public service spirit that has sparked various stages of his business and civic career. Milk stations for babies, a hotel for homeless men, model housing projects . . these are but a few of the welfare projects that, under his zestful idealism and vigorous competence, blossomed into reality. This while he was a young attorney.

Later, during his eight-year term as New York State Superintendent of Insurance, he overhauled the insurance laws to guarantee fair treatment both to the public and to the companies.

Then, during World War II, when the OPA needed a man to untangle complex landlord-tenant disputes, Mr. Pink was drafted for the job. He served without salary. Both landlord and tenant respected and had confidence in him.



Louis H. Pink . . the subject of this study

Early in 1934 he accepted the presidency of Associated Hospital Service and almost immediately inaugurated the progressive policies which started New York's Blue Cross Plan on its steady climb upward. As a director of the National Foundation for Infantile Paralysis for many years, Mr. Pink was naturally interested in the problems of polio victims. His active efforts in their behalf . . among them the New York Plan's granting of hospitalization benefits to cover polio (though Blue Cross contracts do not otherwise cover communicable diseases requiring isolation and quarantine) . . made him a logical choice for the job of general chairman of the polio drive.

In the eight years since he became the New York Plan's vigorous chief executive and later chairman of its board, Mr. Pink has played a major part in its spectacular development: enrollment regulations were liberalized to make the Blue Cross available to additional millions . . nongroup enrollment was encouraged, age limits raised from 60 to 65.

Under his regime benefits were increased again and again. The all-inclusive "service contract" was put into effect, making it possible for 92 per cent of non-maternity patients in semi-private accommodations to have their hospital bills paid in full. Unions, aware of the growing value of Blue Cross services, added thousands to its roster. In recognition of their interest, both a CIO and an AFL representative were elected to the board.

Long before the rise of Blue Shield, Mr. Pink advocated medical insurance to supplement hospitalization. His vigorous efforts were largely responsible for bringing about the merger of Community Medical Care and Medical Expense Indemnity Fund to form United Medical Service, now America's largest Blue Shield Plan. Although UMS functions with its own board of directors, mostly physicians, its sales and administration are handled by AHS.

Mr. Pink's special talents . . his vibrant energy, personality and integrity, his ability to bring order out of chaos . . were recognized in 1945 by Sergio Osmena, president of the Philippine Islands. During the three years of enemy occupation many official records had been lost or destroyed. Obstacles to recovery seemed endless. Expert guidance was needed to restore the Islands' shattered economic system.

Mr. Pink was the logical man to

BY INTRAVENOUS INFUSION

ACTHAR*

A new hospital procedure for greater efficacy and substantial economy

An intravenous infusion of 20 I.U. of ACTHAR given over an eight-hour period provides activation of the adrenal cortex for approximately twenty-four hours, rapidly initiating ACTH therapy even in the most serious conditions. As treatment continues, the dose can be decreased to as little as 5 I.U. a day with excellent clinical results. Intravenous administration requires but one-fifth to one-tenth the dose given intramuscularly. Therapeutic results have been excellent.

Intravenous infusion of ACTHAR is essentially a hospital procedure and represents the most economic method in emergency treatment of severe or imminently grave conditions.

ACTHAR by intravenous infusion can be used to rapidly initiate therapy in most disease states and is of particular value in acute sensitivity reactions such as drug or serum reactions, acute disseminated lupus erythematosus, pemphigus, most acute inflammatory diseases of the eye, adrenal cortical atrophy following prolonged or excessive adrenocortical substitution therapy, and pre- and postoperatively, especially in surgery of the pituitary gland.

Supplied: In vials of 10, 15, 25, and 40 International Units.

*The Armour Laboratories Brand of Adrenocorticotropic Hormone (Corticotropin—ACTH)

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THE ARMOUR LABORATORIES
CHICAGO 11, ILLINOIS

world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

restore order. In asking the AHS Board to grant Mr. Pink a temporary leave of absence Mr. Osmena wrote: "Your president, Louis H. Pink, is so eminently qualified that he would receive the spontaneous support of every interest involved and could make a contribution to the rehabilitation of the Philippine Commonwealth which would be invaluable to its people." Mr. Pink accepted the challenge and within a few months had the insurance and banking industries functioning.

But Mr. Pink's interests go beyond the national borders. As chairman of the board of the Citizens Conference on International Economic Union, Mr. Pink works diligently to foster peace by promoting economic cooperation among nations. Under his vigorous chairmanship the organization has been steadily gaining recognition for its sound and constructive activities. To advance its monumental program Mr. Pink addresses meetings, corresponds with members and the press, plans and distributes pamphlets on world-wide economic developments.

Mr. Pink's interests seem to know no bounds: an avid reader, a writer, a lover of music, his interests include active membership in organizations connected with health, education, insurance, economics, housing. His contributions to public welfare in the housing field have been truly noteworthy. He drafted the Redevelopment Corporation Law covering the construction of some of the world's largest housing projects. He is the first to have urged a law providing for the New York City Municipal Housing Authority, the largest landlord in the world and the forerunner of several thousand housing authorities in the United States.

Thanks to his vision and enterprise, hundreds of moderate income families in New York City are now comfortably housed in the unique Queensview cooperative development. Built with an initial investment of $50,000 made by ten civic-minded citizens and the major funds of a large insurance company Queensview has been called "a successful experiment in democracy." Less than a year after the project got under way the funds advanced by the directors to promote it were fully repaid.

Patient Edward Welczen, 5, switches on huge new Blue Shield sign in New York. Dr. Leonard J. Raider, Blue Shield v.p., shows him picture of the sign he lighted

Today the sponsors who formed the original board are being replaced by the resident owners so that the latter will eventually have complete control. The projects' policy of non-discrimination has been closely observed in fact and in spirit. Residents enjoy such advantages as a nursery school and summer playground for their children, a cooperative purchasing committee and social clubs for various age groups.

Though he is an idealist, Mr. Pink's approach to all these problems has been most practical and realistic. Despite the multiplicity of his interests and activities he still spends most of his time at AHS where he is often seen in the cafeteria during the lunch hour carrying his tray to join some of the Plan's 2,000 employes. That their affection for the "big boss" is genuine is evidenced by the fact that contributions toward a birthday gift materialize spontaneously each year.

How does this man of indomitable vigor and enthusiasm relax from his strenuous program of activities? In addition to reading, writing and enjoying symphonies, he sails, during seasonable weather, near his summer home in Bayville, Long Island. And his vacations? They're usually spent delving further into the interests that make up his daily routine . . exploring the insurance, housing and health facilities of other nations. In 1950 he explored these programs in the Scandinavian Peninsula; this past summer he continued his explorations in Holland, Austria, Jugoslavia . . a typical busman's holiday. This country needs more men like Mr. Pink. ■

The Michigan picture is a pleasing one

■ THE MICHIGAN Blue Cross Plan which has had its own particular problems is presenting a pleasing picture these days under the capable direction of William S. McNary, executive vice-president.

The Plan has announced that 191 Michigan hospitals . . virtually all eligible acute hospitals in the state . . are now Blue Cross participating hospitals. The Plan's annual income, based on August and September figures, has topped the $50,000,000 mark; enrollment is zooming at the average rate of 35,000 new subscribers monthly. Two in every five men, women and children in the state are now covered by the Blue Cross.

And *why* is the Plan growing so rapidly? Subscriber enthusiasm: word-of-mouth advertising coupled with the fact that the Plan is spending over 92 cents out of every dollar of earned income on hospital care for its members, that its operating costs are under five per cent.

During the past year the Plan put approximately 2.77 per cent into reserves. And, according to a study of health insurance plans conducted by the Senate Labor and Public Welfare Committee, Blue Cross pays a much bigger percentage of the average hospital bill; pays out a larger portion of its income dollar to hospitals for services to its members; and provides more permanent protection.

According to this report, insurance companies "in 1949 appear to have paid 45 to 55 per cent of the average bills of their policy-holders, whether under individual or group enrollment." In the same year, according to the survey report, "the 84 Blue Cross Plans in the nation appear to have paid an average of

continued on page 114

19 reasons why your hospital fund-raising program CAN succeed...

Senior Directors of Lawson Associates, Inc., attending Semi-Annual Conference, January 2-3, 1952, at the Waldorf-Astoria, New York*

Twice each year—January and July—all Senior Directors of Lawson Associates, Inc., come together in New York from all over the United States and Canada for two days of concentrated study of fund-raising and public relations methods and techniques. These are the seasoned, carefully trained, permanent members of the Senior Staff of the Corporation. Each has been campaign tested and has the experience, education and personality to represent you and your hospital competently and successfully at every community level.

If you have not received a copy of our New Fact File and brochure, "When Your Hospital Needs Funds" write Dept. A-2

*Seated: Howard R. Lichtwald, Bernard H. Lawson, Cecil P. Dodge, Herbert G. Carhart, Jr., John C. Marcellus, Warren E. Tucker, Harry F. Campbell, Robert S. Niewenhous.
Standing: Daniel F. Mulvey, Robert B. Snook, James H. Fraser, Frank E. Slattery, Edwin E. Staudt, Brendan Sullivan, Robert M. Applewhite, Herbert Scholtz, William Morgan Welsh, Reynolds Johnson, Ernest S. Vena.

Lawson Associates
INCORPORATED

Eastern Office, Rockville Centre, N. Y. Western Office, 420 Market St., San Francisco, Cal.

news from Washington

by Kenneth C. Crain

221 health projects scheduled for approval for next quarter

■ THE OPENING OF 1952 has already witnessed dramatic developments in Washington in connection with the general economic situation and the military rearmament program, with definite and immediate effect upon the hospitals and other segments of the civilian economy.

One of the most significant of these was the announcement on January 15 by the Public Health Service that 221 of the most urgent hospital and health facility projects are scheduled for approval for the second quarter of the year with the controlled materials available for the DPA set-up. Of this number, 23 are new hospitals, 36 represent expansion of bed capacity in existing hospital facilities and 121 are repairs or renovations needed to keep present hospitals in operation. The remaining 41 are non-hospital projects such as clinics and health centers.

This further confirmation of the repeated assurances that hospitals would be taken care of as far as possible in the light of the general shortage of certain materials, on the one hand, and of the appreciation of the basic need for adequate hospital facilities, on the other, has been accepted as gratifying in spite of the continuing lack of any degree of certainty of an improvement in the supply of materials.

Indications certainly point to some such improvement, however, even though it may be temporary. Chief among these is the somewhat disturbing fact that the rearmament program has run into a number of snags, principally related to indecision on design, which have forced postponement of production and thus tended to release large quantities of materials previously set aside.

An outstanding example of the effect of this became public on January 24 when it was announced that the Air Force had released enough aluminum to raise automobile production to 900,000 cars in the second quarter instead of the previously estimated 800,000. The quantity of aluminum released was around two million pounds.

Copper remains extremely scarce, however. The authorization for hospital construction, referred to above, emphasized that copper allocations of all projects are being reduced because of the scarcity of the metal and that substitute materials must be used as far as possible, as in piping. In spite of the repeated comment that there would be no effort to make hospital equipment . . or hospitals themselves . . of substitute materials, the copper situation has compelled revision of this idea.

Conservation measures . . A recent meeting in Washington of the Sterilizer Industry Advisory Committee with the NPA resulted in plans for substantial savings in nickel as well as copper by means of voluntary conservation measures. It was reported by the NPA that this conservation will be accomplished by substituting monel metal for nickel-clad steel, stainless steel for monel, and alloy castings for copper castings, to the extent permitted by specifications.

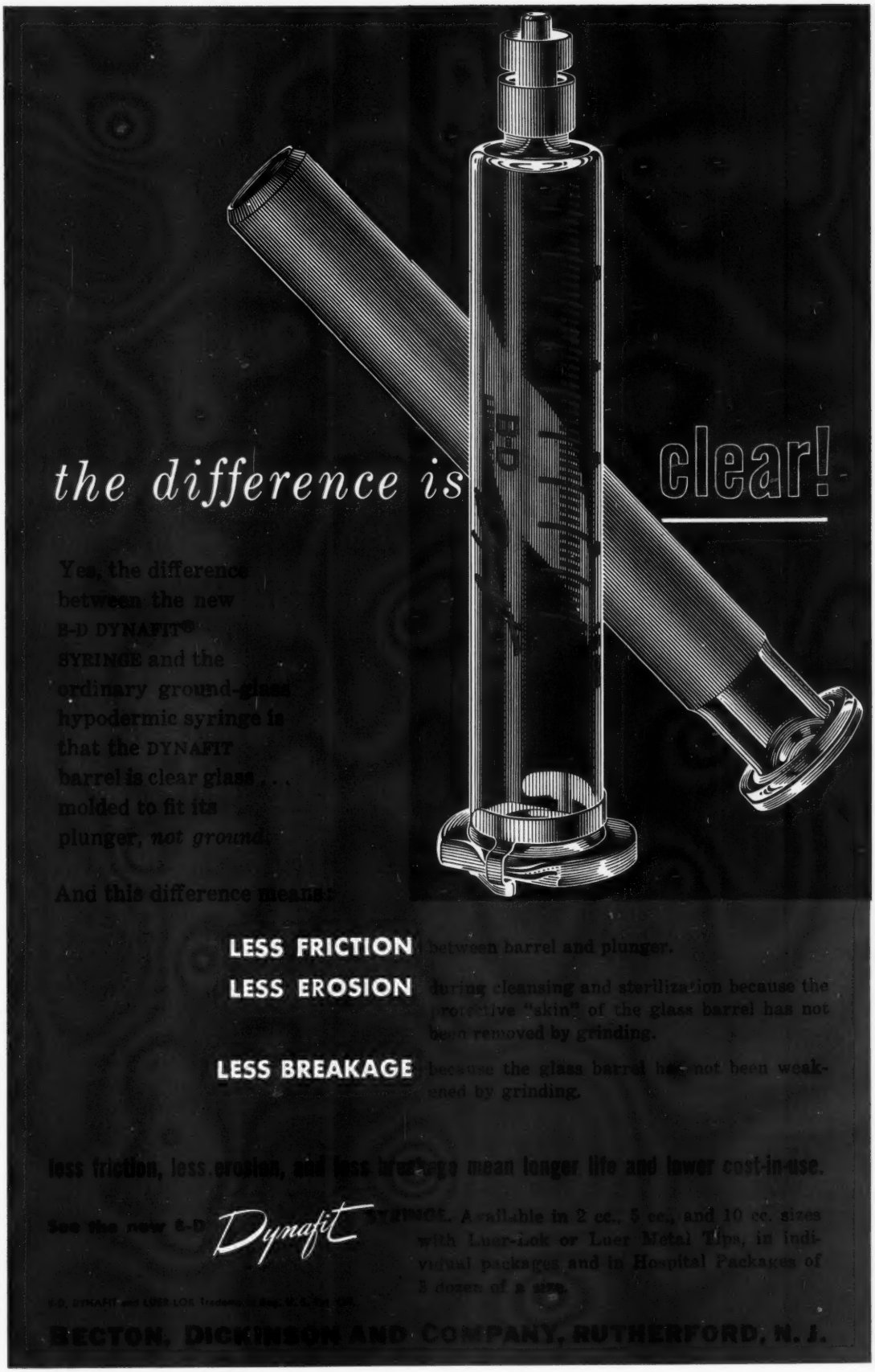
The committee group attending the conference included representatives of seven leading manufacturers of sterilizers and the suggestion that the indicated conservation practices might be imposed on the entire industry by an appropriate order was not opposed. However, the committee was reported as criticizing the military specification of stainless steel sterilizer stands on the ground that such specification wastes the limited quantity of stainless steel available and runs up the cost of the sterilizer unit.

On the other hand spokesmen for the armed forces argued that the saving in both stainless steel and money by using painted or enamel-coated carbon steel is insignificant and that the longer life of the stainless steel stand makes it the more desirable.

A significant statement of the existing demand for sterilizers, which obviously would also apply to other essential hospital equipment, was that combined demand from military and civilian sources is running from 50 to 160 per cent above the base year ending July 1950. Civilian demand was reported as running one-third higher than the base period.

Military first . . One somewhat unexpected aspect of the rearmament program as far as hospital equipment manufacturers are concerned is that with the same products being turned out for both military and civilian hospitals, the rising demand from the armed forces is threatening to leave the civilian institutions with only a fraction of their needs, since there is no set-

continued on page 120


the difference is clear!
Yes, the difference between the new B-D DYNAFIT® SYRINGE and the ordinary ground-glass hypodermic syringe is that the DYNAFIT barrel is clear glass . . . molded to fit its plunger, *not ground*.
And this difference means:
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less friction, less erosion, and less breakage mean longer life and lower cost-in-use.
See the new B-D Dynafit SYRINGE. Available in 2 cc., 5 cc., and 10 cc. sizes with Luer-Lok or Luer Metal Tips, in individual packages and in Hospital Packages of 3 dozen of a size.
BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.

the hospital calendar

List Your Meetings

As soon as the dates for the next succeeding meeting of an organization have been determined an official should forward those dates at once to Editor, Hospital Management, 200 E. Illinois St., Chicago 11, Ill. to insure appearance in this calendar.

February

20-21 . . National Association of Methodist Hospitals and Homes, Statler Hotel, Cleveland, O. Executive secretary, Karl P. Meister, 740 Rush Street, Chicago 11, Ill.

21-22 . . American Protestant Hospital Association, Hotel Statler, Cleveland, O. Executive secretary, Albert G. Hahn, administrator, the Protestant Deaconess Hospital, Evansville 11, Ind.

25-29 . . AHA Institute for Nurse Anesthetists, Minneapolis.

March

10-April 5 . . Hospital laundry management training course, State University of Iowa, Iowa City.

14-15 . . Alabama Hospital Association, Russell Erskine Hotel, Huntsville, Ala.

17-21 . . AHA Nursing Service Institute, Boston.

17-21 . . AHA Dietary Department Management Institute, Cincinnati.

24-26 . . New England Hospital Assembly, Statler Hotel, Boston, Mass. Secretary, Theodore F. Childs, Brockton Hospital, Brockton, Mass.

25-27 . . Kentucky Hospital Association, Seelbach Hotel, Louisville, Ky.

27-28 . . AHA Safety Institute, Boston.

31-April 3 . . Blue Cross-Blue Shield Annual Conference, Fairmont and Mark Hopkins Hotels, San Francisco.

31-April 3 . . Ohio Hospital Association, Hotel Cleveland, Cleveland, O., Executive secretary, Harry C. Eader, 55 E. State St., Columbus 15, Ohio.

31-May 23 . . Hospital housekeeping short course, Michigan State College, East Lansing, Mich.

April

14-15 . . AHA Personnel Relations Institute, Atlanta.

16-18 . . Southeastern Hospital Conference, Atlanta Biltmore Hotel, Atlanta, Ga. Executive Secretary, R. G. Ramsay, Jr., assistant superintendent, Gartly-Ramsay Hospital, Memphis, Tenn.

21-22 . . AHA Public Relations Institute, Kansas City.

23 . . Iowa Hospital Association, Kirkwood Hotel, Des Moines.

23-25 . . Mid-West Hospital Association, President Hotel and Municipal Auditorium, Kansas City, Mo. Executive secretary, Anne Walker, 601 Pickwick Bldg., 903 McGee St., Kansas City 6, Mo.

24 . . West Virginia Hospital Association, Roanoke Hotel, Roanoke, Va.

24-25 . . Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va. Secretary-treasurer, J. Stanley Turk, Ohio Valley General Hospital, Wheeling, W. Va.

28-30 . . Tri-State Hospital Assembly, Palmer House, Chicago, Ill. Executive secretary, Albert G. Hahn, administrator, Protestant Deaconess Hospital, Evansville 11, Ind.

May

1-2 . . AHA Operating Room Administration Institute, Chicago.

5-6 . . Arkansas Hospital Association, Arlington Hotel, Hot Springs, Ark.

12-13 . . AHA Trustee Institute, St. Paul.

12-15 . . Association of Western Hospitals, San Francisco, Calif. Executive secretary, Melvin C. Scheflin, Association of Western Hospitals, 26 O'Farrell Street, San Francisco 8, Calif.

14-16 . . Upper Mid-West Hospital Conference, Lowry and St. Paul Hotels, St. Paul, Minn. Executive secretary, Glen Taylor, Students' Health Service, University of Minnesota, Minneapolis, Minn.

19-20 . . AHA Purchasing Institute, Atlantic City.

20 . . Connecticut Hospital Association, Southern New England Telephone Co. Auditorium, New Haven, Conn.

19-23 . . AHA Engineering Institute, Chicago.

20-22 . . Texas Hospital Association, Shamrock Hotel, Houston, Texas. Executive secretary, Ruth Barnhart, 2208 Main St., Dallas 1, Texas.

21-23 . . Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N. J. Convention manager, J. Harold Johnston, 506 E. State St., Trenton 9, N. J.

21-23 . . New Jersey Hospital Association, Convention Hall, Atlantic City, N. J.

24-25 . . Catholic Schools of Nursing Conference, Public Auditorium, Cleveland, O. Secretary, Margaret Foley, 1438 South Grand Blvd., Saint Louis 4, Mo.

25-30 . . American Society of X-ray Technicians, Morrison Hotel, Chicago, Ill.

26-29 . . Catholic Hospital Association, Public Auditorium, Cleveland, O. Executive director, Rev. John J. Flanagan, S.J., 1438 South Grand Blvd., Saint Louis 4, Mo.

June

16-20 . . American Nurses Association, National League of Nursing Education, National Organization for Public Health Nursing, Atlantic City.

September

13-18 . . Hospital Management public relations meeting, American College of Hospital Administrators, American Hospital Association, American Association of Nurse Anesthetists, Hospital Industries Association, Philadelphia.

How they kept their new hospital from being old-fashioned before it opened!

Much to the relief of these board members, the consulting engineer has just reported that Individual Room Temperature Control can still be installed in their new hospital!

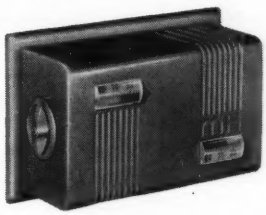
This is what happened, according to one board member:

"Our original plans did include Individual Room Temperature Control! However, in a series of economy moves, we arbitrarily left it out. Then we learned it would only cost ½ to 1% of our total expenditure – and that our new hospital would literally be dated without it! We sure changed our minds in a hurry!"

No doubt about it, in many hospitals it is already routine medical practice to give each patient the exact room temperature he needs as a means of speeding convalescence. And you can do this *only* with Individual Room Temperature Control. No other system can compensate for the varying effects of wind, sun, open windows and variations of internal load in each room.

Since that is true, it's just smart business to install individual room temperature controls *when your hospital is being built.* Doing it later, as a modernization project, is sure to cost substantially more money.

For complete facts and figures on Honeywell controls for your hospital, call your local Honeywell office – there are 91 of them located in key cities. Or for literature, write Minneapolis-Honeywell Regulator Co., Dept. HM-2-27 351 E. Ohio St., Chicago 11, Illinois.



Only thermostat specially designed for hospitals!

Honeywell's new Hospital Thermostat is the only thermostat to offer three *special features* that provide maximum hospital efficiency. 1. Honeywell's exclusive *"Nite-glowing dials"* permit inspection without disturbing patients. 2. *Magnified numerals* make readings easier to see. 3. The new *speed-set control knob* is camouflaged against tampering! And like other fine Honeywell controls, this new Hospital Thermostat is highly sensitive, accurate and dependable – with a simple, rugged mechanism that reduces maintenance.

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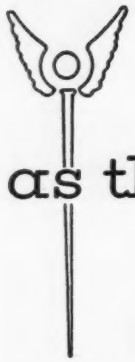

as the editors see it

Budgets can be balanced

■ HOSPITALS typically operate on a deficit basis although the difficulty of getting regular annual contributions to meet the deficit has increasingly led well-managed institutions to vigorous efforts to avoid a deficit. Being unlike the Federal and other governments which, when confronted with a budget which is a good deal more than revenue in sight, can seek "other sources of revenue," the hospital in such a case has to look both for ways of cutting expenditures and of securing additional income.

Action . . Public spirited business man heading the board of a leading hospital was discussing this not long ago with a friend and spoke of the deficit of the second preceding calendar year. It had arisen out of the same factors as those which confront hospitals everywhere, including shorter hours and higher pay for all grades of personnel, higher food and fuel costs, and, on the revenue side, inadequate compensation from several of the third party agencies responsible for patients. The resulting deficit was not too disturbing except to a good business man who, as in this case, does not like to be responsible for an operation which is not paying its way. So he got busy.

The fact that the hospital had been suffering substantial losses not only because of inadequate welfare payments, but because Blue Cross payments were considerably less than actual cost, left these respective third parties with no real argument against the hospital's case. The hospital's deficit due to Blue Cross was so large that it played an important part in inducing the latter organization to announce a general readjustment in its scale of rates.

He arranged, after due deliberations in the board and discussions with the administrator, for higher rates throughout the hospital, adjusted to the varying services and definitely not excessive as to any of them. He approached the local governmental agency responsible for payment for those who could not pay for their own care and showing the hospital's per diem cost figures and explaining the effect of rising costs all around, secured a modest . . but in the aggregate substantial . . increase in the payments for these patients.

Blue Cross was next on his list. The negotiations were started promptly, however, and were successful in a surprisingly short time in bringing about a better Blue Cross rate. This was a real victory, valuable to all of the hospitals in the State and not too burdensome to their partner, the service plan.

The third factor in better revenue for the hospital was one of the most interesting of all and brought the board president into contact with one of the most bitterly debated issues in the whole field, that of the compensation of the specialists operating exclusively in the hospital. Having examined carefully the figures of the past few years' operations of the radiological and laboratory departments, however, our business man was prepared so completely that he had comparatively little real difficulty in putting his proposals across to the heads of these departments, the competent medical men who, he confidentially reported, were doing rather exceptionally well through the previous arrangement.

His proposals, differing in detail but the same in principle, were to the net effect that a certain reasonable percentage of gross income for these departments should be paid to the hospital to cover its investment and other items of overhead; that in each case the department head should be paid an agreed amount to cover what might be called his overhead and that there should be a sliding scale of division of the balance between the hospital and the department head with the hospital receiving a higher percentage as the total amount rose. The arrangement was so reasonable that agreement was ultimately reached.

The board president proudly produced the figures which resulted from these several adjustments last year. Due to delays in securing the actual effectiveness of all of them, the deficit for the first half of the year was only slightly less than that of the preceding year; but for the latter half the deficit had disappeared. The hospital is now operating in the black, he declared.

Solution . . These precise steps are not feasible in every case nor could it be said that in every case they would work out successfully. Every locality differs from every other locality in one respect or another, as for example in the percentage of Blue Cross patients, which may range from zero to 50 or 60. But the basic factors of the problem are actually the same everywhere and the problem can be solved by firm, persistent and intelligent attack along these lines. It has been done in a good many cases. ■

A hospital is a handy thing

■ LESS THAN AN HOUR before the airplane crash in the heart of Elizabeth, N.J., in which 30 persons were killed and a number of others, residents of the city, were injured, the nursing head of one of the local hospitals had impressed upon her nurses the fact that while atomic bombing might not be imminent, such destructive accidents as plane wrecks must always be considered possible. This warning came from Sister Maria Lawrence, directress of nurses at St. Elizabeth's Hospital, a 229-bed institution, in a talk to her 43 nurses, during a meeting which ended at 3:15 p.m. The crash occurred at 3:30 and the hospital immediately sent some of these same nurses to the scene of the disaster, whence the injured were brought back for all possible care.

So dramatic a coincidence is hardly needed to emphasize the fact that in this increasingly mechanized age the community hospital is a splendid thing to have around, indispensable in fact to the life of surprisingly continuous danger of modern man.

It just happens that during the past year or so the area around Greater New York, including the metropolitan New Jersey section, has been the scene of rather more than its share of tragic accidents, no less than three ghastly railroad wrecks figuring in the gloomy list, while an airplane crash only a few weeks before the one referred to above, in the same city, produced no work for the hospitals because there were no survivors.

In the train wrecks, however, there were scores of terribly injured and the magnificent work of the

continued on page 120

hm 25 years ago

■ AUGUSTANA HOSPITAL in Chicago, Illinois, was the featured hospital in the February, 1927 number of **'hm.'** Two articles were devoted to it. The first, by Rev. Axel N. Nelson, S.T.D., secretary of the institution's board of directors, provided a historical sketch which led up to the opening in 1926 of a new unit. This addition, which comprised the east wing and the administration building, had been dedicated by Crown Prince Gustaf Adolph of Sweden. The second article presented floor plans and detailed examination of special layouts and equipment under the title, "X-ray, Kitchens Are Features of New Buildings of Augustana."

■ NURSES AND NURSING also came in for a double treatment. The lead article, "What Part Can Group Nursing Play in Cutting Cost of Hospital Care?" summarized opinions of prominent individuals without coming to a clear-cut conclusion either way. The passage of time since then seems to have settled the question.

Three pages were devoted to the problem of recreational facilities for nurses. The consensus of a symposium was that large space for lounging, dancing and informal relaxation was in greatest favor among student nurses, while athletic programs of such sports as swimming, tennis and basketball did not possess general interest (although featured in some schools).

■ HOSPITAL STATISTICS were presented in an article that was a forerunner of 1952's "How's Business" department. It, however, was on a one-time basis in the February, 1927 issue, whereas much more comprehensive data are published systematically every month now.

At any rate, 105 hospitals of 50 beds or over submitted complete reports. The results were totaled and averaged as follows: Total bed capacity, 14,995 . . average, 143; number of employes, 6,927 . . average 66; student nurses, 4,862 . . average, 46; patient days, 3,582,019 . . average, 34,114. The average number of patients per day per hospital was 93, and the average number of employes and student nurses, 112.

■ MATTHEW O. FOLEY, then managing editor, analyzed an annual report with perspicacity in "How a 'Good Annual Report' May Kill Confidence of the Public." One injunction that cannot be repeated too often was ". . . the annual report not only should be prepared in an interesting way from the standpoint of text and illustrations, but should be printed so attractively that it will stand favorable comparison with the many high-grade pieces of printing that may arrive at the home at about the same time the report is received." Of particular concern to the author, however, were seven pages of diseases and conditions in tabulated form with columns of figures under headings: Total, Cured, Improved, Unimproved, Died and Remaining. The reaction of a newspaperman to this summary was interesting; he stated that the mysterious names of conditions only formed in his mind pictures of deformities, bloodshed and agony, while the percentages of fatalities seemed abnormally high for a Class A-1 hospital. Fortunately, few hospitals think that the dissemination of such information is necessary or discreet these days.

■ OTHER INFORMATIVE PIECES in the issue were "How Management and Efficiency Can Be Applied to Hospitals," by Professor A. D. MacGibbon of the University of Alberta, "Attending Conventions Part of Trustee's Duty to Hospital," by Louis J. McKenney, chairman of the board of Highland Park (Mich.) General Hospital, and "What is the Best System for Keeping Complete Record of a Patient?" by Margaret L. Innes, registrar of Toronto's Wellesley Hospital. ■

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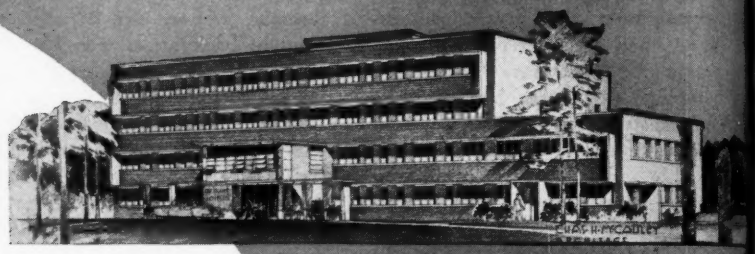

Lee County Hospital and Health Center, Opelika, Alabama
Architect and Engineer: Charles H. McCauley, Birmingham, Alabama
Contractor: Capital Refrigeration Co., Inc., Montgomery, Alabama

John Sealy Hospital, University of Texas, Medical Branch, Galveston, Texas
Architects: C. H. Page & Son, Austin, Texas
Consulting Architects: Eggers & Higgins, New York, N. Y.
Mechanical Engineers: Zumwalt & Vinther, Dallas, Texas
Contractor: Farwell & Company, Dallas, Texas

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Sparks Memorial Hospital, Fort Smith, Ark.
Architect: E. Chester Nelson, Ft. Smith, Ark.
Engineers: Carnahan & Thompson, Oklahoma City, Okla.
Contractor: G. W. Shirley & Son, Van Buren, Ark.

For Greatest Comfort and Lowest Maintenance Cost Use POWERS Control

Bergen Pines County Hospital, Paramus, New Jersey
Architects: York & Sawyer, New York City
Engineer: Jaros, Baum & Bolles, New York City
Contractor: Frank A. McBride Co., Paterson, N. J.

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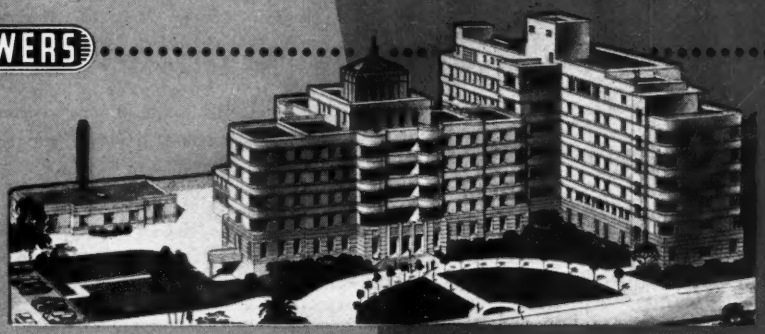

St. John's Hospital, Santa Monica, Cal.
Architect: John W. Maloney, Seattle, Wash.
Engineers: Lincoln Boullion & Associates, Seattle, Wash.
Contractor: Johnston & Washer, Los Angeles, Cal.

POWERS

Veterans Administration Hospital, Wilkes Barre, Pa.
Architects-Engineers: Kelly & Gruzen and Isadore Rosenfield
Mechanical Engineer: Edward E. Ashley
Contractor: Frank A. McBride Co., Paterson, N. J.

(484)

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who's who in hospitals

Administrators & assistants

Ahlstedt, Paul . . Appointed administrator, Wichita General Hospital, Wichita Falls, Texas.

Barnett, E. Dwight, MD . . see story on page 80.

Baum, Carl R. . . Promoted to post of assistant director, Children's Hospital, Buffalo, N.Y. He has been associated with the hospital as business manager since December 1948, and prior to that had been office manager of the Hospital Service Corporation of Western New York.

Boyer, John M. . . Named assistant administrator, Halifax District Hospital, Daytona Beach, Fla., after serving since Feb., 1950 as director of the personnel service department, Wesley Memorial Hospital, Chicago. His successor at Wesley is **Robert E. Willcox,** who has served there as assistant to the superintendent, on evening service, since Sept., 1948.

Braswell, Taylor O. . . Assumed duties as administrator, Fairfield Memorial Hospital, Fairfield, Ill., succeeding **Alfred Van Horn III,** who resigned to become assistant executive director of the American College of Hospital Administrators. Mr. Braswell, who received his M.H.A. from Northwestern U., is a member of the A.H.A. and an A.C.H.A. nominee.

Cartmill, George E. . . see story on page 80.

Daughety, R. O. . . Appointed director, University Hospital, Augusta, Ga., after resigning as administrator of City Memorial Hospital, Winston-Salem, N.C.

DeVane, James . . Resigned as administrator, Sampson County Memorial Hospital, Clinton, N.C., to accept the post of administrator of the Thompson and Baker divisions, Robeson County Memorial Hospital, Lumberton, N.C.

Douglas, Frank . . Named administrator, Pemiscot County Memorial Hospital, Hayti, Mo., succeeding **Lynn H. Roberts,** resigned.

East, Isaac, MD . . Named superintendent, Spencer State Hospital, Spencer, W. Va., after having served since 1947 as clinical director of the Eastern State Hospital, Williamsburg, Va. and also as director of the Lower Peninsula Mental Hygiene Clinic, Newport News, Va.

Finn, Thomas J. . . Appointed superintendent, Pollak Hospital for Chest Diseases, Jersey City, N.J., succeeding **Dr. Frederic J. Quigley,** retired. Mr. Finn, who has been with the civil service for 13 years, has a Master's degree in public personnel administration from N.Y.U.

Frye, Edward R. . . Named administrator, Good Samaritan Hospital, Charlotte, N.C. For the past year and a half, Mr. Frye has been administrator of the Caldwell County Memorial Hospital, Lenoir, N.C.

Gantt, Robert M., Jr. . . see **Lockhart** notice

Golden, Thomas J. . . Retired as administrative director of the Medical Center, Jersey City, N.J. Mr. Golden is a Fellow of the A.C.H.A.

Golding, Walter . . Appointed superintendent of the city-operated Memorial Hospital, Colorado Springs, Colo., succeeding **H. F. Zimoski, Jr.**

Griffith, Charles M., MD . . Retired as manager of the V-A Mount Alto Hospital, Washington, D.C. After joining the V-A in 1924, he served from 1931 to 1945 as its medical director, at which time he became manager of Mount Alto.

Heron, Donald A. . . Named assistant administrator and business manager of Holzer Hospital, Gallipolis, Ohio. Mr. Heron was formerly comptroller, Springfield City Hospital, Springfield, Ohio and prior to that at Montefiore Hospital, Pittsburgh. He is a personal member of the A.H.A. and a past president of the Southwestern Pennsylvania Accountants Assn.

Hemsworth, Rodney W. . . Named administrator, Norways Foundation Hospital, Indianapolis, Ind., after serving for 3 years as administrative assistant at the General Hospital Division of the Medical Center, Jersey City, N.J. Prior to that he was associated with the U. of Minnesota Hospitals for 6 years. A Marine veteran of WW II, Mr. Hemsworth holds B.B.A. and M.H.A. degrees from the U. of Minnesota; he is a Nominee of the A.C.H.A.

King, Florence . . Resigned as administrator, the Jewish Hospital, St. Louis, Mo. Her successor is **Dr. David Littauer,** formerly of Menorah Hospital, Kansas City, Mo. Miss King has been associated with the Jewish Hospital since 1926, and served as administrator there since 1939. She is a member of the A.C.H.A., the A.H.A. and a number of other organizations, having been president of the Mid-West Hospital Assn. and the Missouri Hospital Assn.

Lockhart, John K. . . Named administrator, Roanoke-Chowan Hospital, Ahoskie, N.C., succeeding **Robert M. Gantt, Jr.,** who is now administrator of the Stanly County Memorial Hospital, Albemarle, N.C. Mr. Lockhart is a recent graduate of the hospital training program at Duke U., Durham, N.C.

Mallon, John B. . . Appointed superintendent, Suburban General Hospital, Pittsburgh, Pa., succeeding **Mrs. Lucetta K. Rose,** who resigned because of ill health. Mr. Mallon, a graduate of Duquesne U., has been associated with the hospital since 1946, and has served since 1949 as assistant superintendent. The hospital launched a $400,000 fund campaign last month.

continued on page 72

VERILOID*

A potent hypotensive principle biologically standardized in mammals[1]

Veriloid represents the sum of the clinically desirable, purified hypotensive ester alkaloids fractionated from Veratrum viride by an exclusive Riker process. Veriloid provides the refined active principles of the crude drug, and on a weight basis represents less than one tenth of one per cent of the whole plant from which it is derived. Veriloid is biologically standardized in mammals,[1] with drop in blood pressure as the end point; hence, results are directly transferable to man, with complete assurance of pharmacologic uniformity.[2, 3]

The purification and standardization of Veriloid permit its administration by weight in milligrams, based on hypotensive activity in mammalian test animals. This exactitude in dosage gives Veriloid therapy a clinical flexibility that makes possible avoidance of adverse reactions. Through elimination of the natural variables in potency of the whole dried plant which lead to side actions, Veriloid therapy has achieved clinical uniformity with striking hypotensive effects in all forms of blood pressure elevation.[4, 5]

The usual daily requirement of Veriloid is 9 to 15 mg., given in divided dosage three times daily, every 6 to 8 hours, the first dose to be taken after breakfast. The evening dose may be 1 or 2 mg. larger than the other two doses of the day. However, requirements for Veriloid vary from patient to patient, and careful dosage determination on each patient is essential for maximum therapeutic effectiveness.

Veriloid is supplied in 1, 2 and 3 mg. tablets, in bottles of 100, 500 and 1,000.

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Containing Veriloid (2 mg.), phenobarbital (15 mg.), and mannitol hexanitrate (10 mg.), Veriloid-VPM provides valuable sedation and the vasodilating action of mannitol hexanitrate. This combination usually makes possible reduced dosage without sacrifice of therapeutic efficacy. Also, phenobarbital adds the advantage of increasing the spread between effective therapeutic dosage and the dosage at which side reactions occur.

VERILOID WITH PHENOBARBITAL

Veriloid With Phenobarbital (Veriloid, 2 mg., phenobarbital, 15 mg.) provides sedation without the action of mannitol hexanitrate. It is valuable when emotional tension must be controlled.

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Littauer, David, MD . . see **King** notice

Miller, Henry . . Formerly superintendent for many years at Hubbard Hospital, Nashville, Tenn.; now engaged in counselling on hospital construction in Nashville. Mr. Miller is a construction engineer.

Pratt, George O., MD . . Appointed manager of the V-A Hospital, Brooklyn, N.Y., succeeding **Dr. Linus A. Zink,** who recently was transferred to the managership of the V-A Mt. Alto Hospital, Washington, D.C. Previously Dr. Pratt was manager of the V-A Hospital at Manchester, N.H.

Quigley, Frederic J., MD . . see **Finn** notice

Roberts, Lynn H. . . see **Douglas** notice

Rose, Lucetia K., Mrs. . . see **Mallon** notice

Slater, Harold L. . . see following item

Starr, Vernon A. . . Resigned as administrator, Lexington Community Hospital, Lexington, Neb., in order to devote full time as consultant to the planned expansion of that institution from 20 beds to 44 beds, together with modernization of the existing facility. His successor is **Harold L. Slater.**

Vanderwarker, Richard D. . . see story in adjoining column.

Voorhies, Daniel J., MD . . Appointed director, Lafayette Tuberculosis Hospital, Lafayette, La., a post vacant since the resignation of **Dr. J. J. Rester** 2 years ago. The appointment is effective July 1. At present Dr. Voorhies is chief of the tuberculosis service of the Dibert Memorial Unit in New Orleans.

Whitbeck, Franklin P. . . Named director of development, Norwalk Hospital, Norwalk, Conn., responsible for carrying out long-range expansion plans. Previously, Mr. Whitbeck was promotion director for Parade Publications, Inc.

Zimoski, H. F., Jr. . . see **Golding** notice

Zink, Linus A., MD . . see **Pratt** notice

Nurses and nursing

Church, Ellen, RN . . Assumed duties as director of nursing and of the School of Nursing, Union Hospital, Terre Haute, Ind. A graduate of the U. of Minnesota School of Nursing, Miss Church was formerly director of nurses and of the School of Nursing, Sherman Hospital, Elgin, Ill., and Children's Hospital, Louisville, Ky. The first airline stewardess, she originated the stewardess service for United Airlines in 1930. Miss Church received her Master's degree in Nursing Education and Administration from the U. of Chicago Dec. 21, 1951.

Hudson, Doris, Mrs., RN . . Appointed assistant superintendent of nurses, Lexington Community Hospital, Lexington, Neb. Mrs. Hudson is a graduate of the Presbyterian School of Nursing, Denver, Colo.

Odell, Elizabeth W., RN . . Named director emeritus of the School of Nursing and of Nursing Service at Evanston Hospital, Evanston, Ill., after her retirement following 26 years as director of those activities.

Slater, Nadyne, Mrs., RN . . Appointed superintendent of nurses, Lexington Community Hospital, Lexington, Neb. Mrs. Slater is a graduate of the Broadlawns County Hospital, Des Moines, Iowa.

Honorariums

Moeller, E. C. . . Chosen as "man of the year" for the state of Indiana, to receive the key of merit awarded annually by the Tri-State Hospital Assembly, highest award to one person from each of the 4 participating states who has made an

continued on page 74

Vanderwarker leaves Passavant for N.Y.C. cancer center

■ RICHARD D. VANDERWARKER, director of Passavant Memorial Hospital, Chicago, for the past 4½ years, has resigned, effective April 1, to become administrative director of Memorial Center for Cancer and Allied Diseases, N.Y.C.

Mr. Vanderwarker, who is also assistant director of the School of Hospital Administration at Northwestern University, served as a lieutenant commander in the Navy during World War II. Prior to his Passavant post, he had been resident manager of the Ambassador Hotels in Chicago and of the Bellerive Hotel, Kansas City.

Memorial Center is the world's largest institution devoted to cancer research and treatment. It employs more than 1,200 persons and includes Sloan-Kettering Institute, the James Ewing Hospital, Strong Cancer Prevention Clinic and the Tower Cancer Clinic. ■

Women's Medical Specialist Corps chief retires

■ COLONEL EMMA E. VOGEL, first Chief of the Women's Medical Specialist Corps, was one of three retiring colonels honored by the Military District of Washington at a retirement ceremony held at Fort Meyer, Virginia.

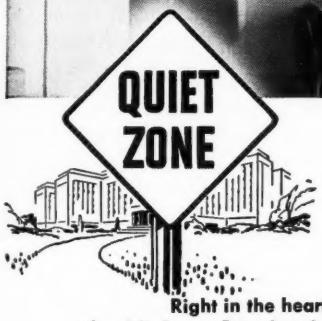
Colonel Vogel has a long and distinguished record of service with the Army Medical Service. Her Army career began in 1919 when she was appointed a physical therapist at Army General Hospital No. 24, near Pittsburgh, Pa., but she is most widely known for her work at Walter Reed Army Hospital, in Washington, D. C.

After the first world war, Colonel Vogel helped organize the first postwar training course in the country for physical therapists. This course was at Walter Reed Army Hospital and was among the first such courses to receive professional recognition from the American Medical Association.

In 1952, Colonel Vogel was transferred to the Office of The Surgeon General of the Army to effect an organization for Physical Therapists. In January 1943, she was appointed a major in the Army of the United States.

She was awarded the Legion of Merit for effectively organizing the Physical Therapist Branch and for formulating policies and plans to insure the highest standards for treatment for the sick and wounded.

She is a charter member of the American Physical Therapy Association and is chairman of the Women's Medical Specialist Corps Section of the Association of Military Surgeons of the United States.



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GET A FREE ANALYSIS of the particular noise problem in your hospital without obligation. Write now for the name of your local distributor of Acousti-Celotex products. You will also receive free an informative booklet, "The Quiet Hospital." The Celotex Corporation, Dept. N-22, 120 S. LaSalle St., Chicago 3, Ill. In Canada, Dominion Sound Equipments, Ltd., Montreal, Quebec.

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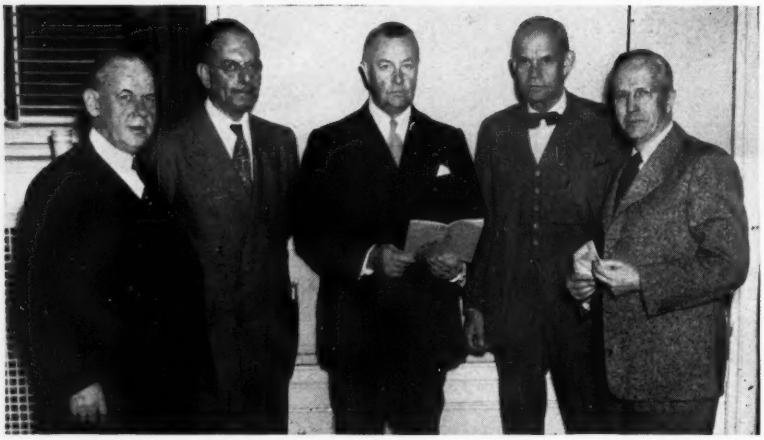
Hardwick succeeds Cheston as chairman of the Hospital Council of Philadelphia



Current officers . . of the Hospital Council of Philadelphia

■ Gordon A. Hardwick, president of the Graduate Hospital of the University of Pennsylvania, was elected chairman of the Hospital Council of Philadelphia for 1952. He succeeds J. Hamilton Cheston, a trustee of Woman's Medical College and Hospital, who served for three and a half years.

Present officers of the Council are shown above as follows (left to right): Walter B. Gibbons, trustee of Misericordia Hospital, vice-chairman; Jerome Bennett, trustee of Jewish Hospital, treasurer; Mr. Hardwick; T. Truxtun Hare, president of Bryn Mawr Hospital, vice-chairman; and C. Rufus Rorem, executive director. Thomas M. Farr, president of Cooper Hospital, Camden, N.J. (not shown in the picture) is secretary of the Council.

outstanding contribution to the hospital field. Mr. Moeller, the 12th president of the Indiana Hospital Assn. (1934), is administrator of the Lutheran Hospital, Fort Wayne.

Overholser, Winfred, MD . . Presented with the medal of a Knight of the Legion of Honor, a French military and civilian decoration. The presentation, accorded because of Dr. Overholser's contributions to world psychiatry, was made by Dr. Yves Porc-her, psychiatrist and hero of the French Resistance movement in WW II. Dr. Overholser is superintendent of St. Elizabeth's Hospital, Washington, D.C.

Sister Carmelita Manning, R.S.M. . . Chosen as "woman of the year" for the state of Michigan, thus qualifying as recipient of the key of merit of the Tri-State Hospital Assembly. This honor is bestowed on one person from each of the 4 states which participate in the Assembly. At present Sister Carmelita is in charge of new construction for the Mercy Order.

Miscellaneous posts

Dixon, James P., MD . . Resigned as manager of health and hospitals, Denver, Colo., to accept the posts of health commissioner, Philadelphia, and of professor in the department of public health and preventive medicine at the U. of Pennsylvania. Dr. Dixon, a graduate of Harvard Medical School, had remained in his Denver position for 4 years.

Powell-Tuck, James . . Resigned as director of development, Norwalk Hospital, Norwalk, Conn., to accept the vice-presidency of the Episcopal Church Foundation, New York. His successor is **Franklin P. Whitbeck.**

Powers, Gloria, Mrs. . . Appointed director, personnel department, The Mountainside Hospital, Montclair, N. J., coming to this newly-created post from Harper Hospital, where as director she organized the personnel department. Mrs. Powers, who is a graduate of Upsala College with a B.S. in business administration, served a 1-year internship in personnel administration at St. Luke's Hospital, Cleveland, Ohio.

Ratner, Richard, Mrs. . . Installed last month as president, Home and Hospital of the Daughters of Jacob, Bronx, N.Y. Mrs. Ratner is the daughter of the late **Bertha Dworsky,** who founded the Institution in 1896 and was its first president.

Wiggins, T. D. . . Elected president, board of managers, Hemphill County Memorial Hospital, Canadian, Texas, succeeding **H. S. Wilbur, Sr.**

Wilbur, H. S., Sr. . . see preceding item

Willcox, Robert E. . . see **Boyer** notice under **Administrators**

Deaths

Brickett, Beatrice H., MD, 87 . . Retired superintendent of the Massachusetts Women's Hospital, 1916-41, Boston.

Hughes, Byron J., MD, 47 . . Superintendent of Winnebago State Hospital, Winnebago, Wis., for the past 12 years. On Jan. 15; of a cerebral hemorrhage.

Johnston, Joseph B., MD, 70 . . Personnel and public relations director, Davis Hospital, Statesville, N.C.

Manney, Willis E., MD, 46 . . Manager designate of the new V-A Hospital, Kansas City, Mo. At Wadsworth, Kans., where he was chief medical officer of the V-A center; of cancer.

Moffatt, A. Fraser . . Treasurer of Ottawa Civic Hospital, Ottawa, Ontario, and for some years a member of the board of directors of the Ontario Hospital Association. He was also second vice-president of the American Association of Hospital Accountants. He is survived by his wife and 3 children.

Sister John Gabriel (Mary Ann Ryan), F.C.S.P., 77 . . Former member of the editorial board of Hospital Management and well known figure in the hospital field. In Seattle, Wash., on Dec. 25.

Steeves, E. M., Mrs., 81 . . Former superintendent of several Texas hospitals and clinics. At her home in Dallas; Dec. 28.

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"He that hath pity upon the poor lendeth unto the Lord; and that which he hath given will He pay him again." (Prov. XIX, 17.)

Springfield (Vt.) Hospital reports a gift variety

■ MULTIPLE GIFTS to Springfield Hospital, Springfield, Vt., recently included an Audograph recorder and transcriber, an incubator, eight floor lamps (for bedside use) and a junior "youth bed."

Another civic-minded group proves beneficence

■ THE LIONS' CLUB of Jasper, Indiana, presented a respirator to the Dubois County Memorial Hospital there at total cost of $1,240. Mother Stanislas, the administrator, in expressing her thanks for the contribution and the service thus rendered the community, said, "The Memorial Hospital now has all the equipment practical for a hospital its size."

Hospital in country hails station wagon

■ RURAL HOSPITALS are particularly in need of automotive facilities, so Memorial Hospital of Bedford County, Pennsylvania, which is located in such a rural area, was gratified to receive a modern station wagon. The gift, from a local automobile dealer, will be used to transport staff members and supplies.

Nationalized status loses gifts for two English hospitals

■ BEQUESTS TO TWO INSTITUTIONS in Great Britain were voided by the Rhode Island Supreme Court because of changed conditions under the British National Health Service Act of 1946. As a result of the decision, the London Hospital and the Elizabeth Garrett Anderson Hospital (also in London) are losing out on an income of between $25,000 and $30,000 which is invested in real estate. The donor was the Rev. Alexander G. Mercer, Newport, R.I., millionaire who died in 1885.

The gifts were predicated on the institutions' using the funds for charitable work. The court pointed out that under the health act, unusually broad powers were given to the minister of health in connection with his administration and control over funds and properties of the hospitals. It also said that there appeared to be emphasis placed on the use of trust funds for the promotion of medical research and for the furnishing of services for patients instead of for the ordinary and usual expenses of operating and maintaining a hospital.

By reason of its provisions, the court said, the health act had brought about a condition which made it impossible for the court to be reasonably certain that the funds would be applied by the hospital boards for the purpose specified in the will.

Westmoreland ends campaign to complete building plan

■ THE NEW WESTMORELAND HOSPITAL in Greensburg, Pa., was assured of completion last month when workers in a $925,000 building fund campaign reported at a "Victory" meeting that a total of $993,993.32 had been subscribed by residents, business firms and others in the Greensburg area.

This was the largest sum of money ever raised in the locality, even though the campaign followed by only seven years a previous building fund appeal by the same hospital, in which $530,000 was contributed.

As a result of the two campaigns and a government grant ($903,844) under the Hill-Burton Act, the new 176-bed addition will be completed early in 1953. Ground for the 9-story building . . the total cost of which will be $2,360,000 . . was broken in May, 1951.

John A. Robertshaw, president of Robertshaw-Fulton Controls Co., Youngwood, served as general chairman of the drive. The firm of Ketchum, Inc. of Pittsburgh was employed as fund-raising counsel.

One person's largess showers Burlington (Ia.) Hospital

■ BURLINGTON HOSPITAL, Burlington, Iowa, was presented with $100,000 in cash and securities as a post-Christmas present by Miss Lydia Dankwardt, longtime resident of Burlington.

She had previously contributed $100,000 toward the current building program on February 1, 1950 and during the fund-raising campaign later that year, another $20,000.

Thus Miss Dankwardt's most recent gift brings her total contribution to $220,000. This sum, along with other funds on hand, assures adequate financing for Burlington's current building program.

"Miniature" idea gives big results

■ PENNY CAMPAIGN TIME is here for the Latter-day Saints Primary Hospital, Salt Lake City, Utah.

The drive is sparked by the imaginative use of miniature pasteboard models of the new Primary Children's Hospital. Each toy-sized replica has a slot in the chimney for penny contributions, and each Mormon churchman is giving a penny for every year of his own age, plus a penny for each year in the lives of his wife and children. ■

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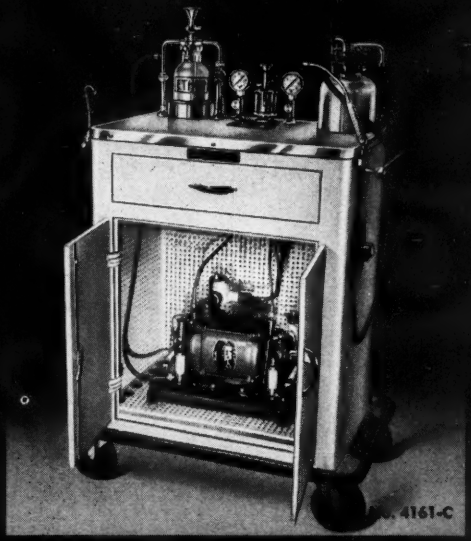

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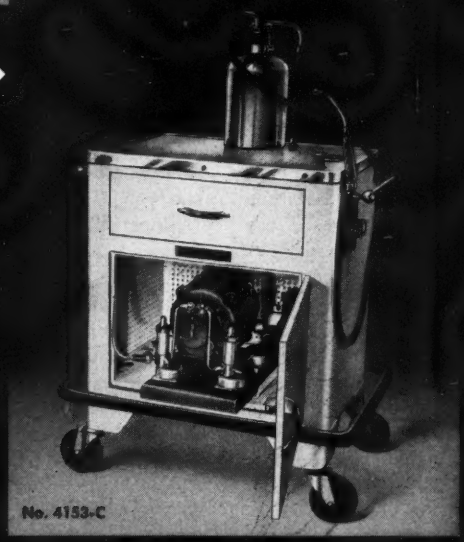

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hospitals and the law

Courts revising decisions on the rights of unborn

by Emanuel Hayt Counsel, Hospital Association of New York State

■ NEW YORK STATE has just been added to the list of states which, during the past year, have held that an unborn viable infant has a cause of action to recover damages for injuries suffered while *in utero*. This new decision reverses the former ruling in that state and follows a similar trend elsewhere.[1]

Early British and American common law gave no answer to the question. In 1884, a Massachusetts court, in the death case of a five-months-old infant, prematurely born, and which survived for a few months after birth, denied a recovery of damages to the estate of the infant on the ground that "the unborn child was a part of the mother at the time of the injury" and that "any damage to it which was not too remote to be recovered for at all was recoverable by her."[2]

A few years later, in 1890, an Irish court refused to allow a suit to be brought on behalf of a child born deformed as the result of an accident.[3] In the early years of this century, rejections of such suits by other courts with various fact situations involving prenatal trauma followed in Alabama,[4] Illinois,[5] Missouri,[6] Rhode Island,[7] Texas,[8] and Wisconsin.[9] New York State first denied such a right in 1921.[10] Massachusetts recently reaffirmed its old decision.[11]

The movement toward a more just treatment of such claims appears to have commenced with a dissenting opinion in an Illinois case in which the mother of an infant sued a hospital. The mother was seated on a stool in the elevator when she fell on account of the negligent operation of the elevator. Both she and the unborn child were injured so that the child was crippled for life. The majority of the court ruled that no cause of action in favor of the child existed unless the child had a distinct and independent existence; the child was a part of the mother and the injury was to her, not to the child. The dissenting opinion, however, urged that a viable child *in utero*, if injured should, when born, be allowed to sue.[12]

Since 1921, when New York State followed the rule denying damages, there have been impressive affirmative precedents. In California, it has been held that "a child conceived, but not yet born, is to be deemed an existing person so far as may be necessary for its interests in the event of its subsequent birth."[13] The Supreme Court of Canada announced the same ruling in 1933.[14] In New Jersey, a strong five to ten dissent unsuccessfully urged the same view.[15]

A Wisconsin court gave impetus to the dissenting view in another case in which it held that it was restricting non-recovery only in case the child is non-viable.[16]

In 1949, the Ohio Supreme Court in two cases,[17] and the Minnesota Supreme Court,[18] as well as the highest tribunals of the District of Columbia,[19] Maryland,[20] Georgia[21] and Louisiana,[22] in 1951, upheld the right of an infant to bring such an action.

The latest New York case, decided on December 6, 1951, in which its former decisions are overruled, states that "to deny the infant relief in his case is not only a harsh result, but its effect is to do reverence to an outmoded, timeworn fiction not founded on fact and within common knowledge untrue and unjustified." ■

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2. Dietrich v. Northampton, 138 Mass. 14, 52 Am.Rep. 242.
3. Walker v. Great Northern R'y of Ireland, 28 L.R. Ir. 69.
4. Stanford v. St. Louis-San Francisco R'y, 214 Ala. 611.
5. Allaire v. St. Luke's Hospital, 184 Ill. 359, 56 N.E. 638.
6. Buell v. United R'ys, 248 Mo. 126, 154 S.W. 71.
7. Gorman v. Budlong, 23 R.I. 169.
8. Magnolia Coca Bottling Co. v. Jordon, 124 Tex. 347.
9. Lipps v. Milwaukee Electric R'y & Light Co., 164 Wisc. 272, 159 N.W. 91.
10. Drobner v. Peters, *supra*.
11. Bliss v. Passanesi, 95 N.E. 2d 206 (Mass.).
12. Allaire v. St .Luke's Hospital, *supra*.
13. Scott v. McPheeters, 92 P. 2d 788, 33 Cal. App. 2d 629.
14. Montreal Tramways v. Leveille, 4 Dom. L.R. 337.
15. Stemmer v. Kline, 17 A. 2d 58, 19 N.J. Misc. 15, rev'd 128 N.J.L. 455, 26 A 2d 489.
16. Lipps v. Milwaukee, *supra*.
17. Williams v. The Marion Rapid Transit, Inc., 152 Ohio St. 114, 87 N.E. 2d 334; Jasinsky v. Potts, 153 Ohio St. 529, 92 N.E. 2d 809.
18. Verkennes v. Corniea and Maternity Hospital, 229 Minn. 365, 38 N.W. 2d 838.
19. Bonbrest v. Kotz, 65 F. Supp. 138 (D.C.I
20. Damasiewicz v. Gorsuch, 78 A. 2d 550 (Md.)
21. Tucker v. Carmichael, 208 Ga. 201.
22. Valence v. Louisiana Power & Light Co., 50 So. 2d 847 (La.)

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GROUPING, TYPING AND BANKING OF BLOOD. By Otaker Jaroslav Pollak. Published by Charles C. Thomas, Springfield, Ill. 163 pp.; $5.75

■ BLOOD BANK PERSONNEL will find this a good manual to have in the laboratory as a reference book. The ten detachable charts should be helpful as they give procedures for running various tests which are performed by a Blood Bank. These charts include the following: grouping of unknown blood, Rh typing of recipient blood or of blood of pregnant women, Rh typing of donor blood, pre-transfusion compatability tests . . cross-matching, compatability test with trypsinated donor's erythrocytes, detection and titration of incomplete A, B, Rh, or Hr antibodies using trypsinated cells as antigen, detection and titration of complete and incomplete A, B, Rh or Hr antibodies with the aid of Comb's serum, Combs' developing test to detect Rh antibodies in cord blood, subgrouping of group A or AB blood and the rapid cardiolipin slide test for syphilis.

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This book well summarizes present knowledge concerning practical theory and technic.

—CAROLYN SYKES, R. N.
Blood Bank Supervisor
University of Chicago Clinics

MEDICAL TERMINOLOGY MADE EASY. By JeHarned, R.N., R.R.I. Published by Physicians' Record Co., 161 W. Harrison St., Chicago 5. 275 pages, sizes 6⅝" x 9¾"; bound in maroon cloth, $5.00

■ WHILE PHILOLOGY HAS A WAY of frightening the uninitiated, its charm is subtle and its spell is such that the student will never cast it off, once he is caught. This truth is brought forth clearly in the delightful and interesting manner in which JeHarned has made the learning of medical terminology an unfolding and rewarding pleasure in her manual on the subject.

Within the limits of her material, she has done for medical language what Mencken did for the "American language," producing a work that is readable, entertaining, and instructive.

The primary aim of the book is to introduce neophytes in the broadening field of medical work to the language of physicians . . especially hospital physicians. It offers practical and well-organized help in understanding the Greco-Latin vocabulary of physicians and surgeons . . with convenient tables of root-words plus their prefixes and suffixes, which lead to a real comprehension of the structure of the medical language.

In other words, it is not a medical dictionary, but a work-book designed to help the student nurse and the general hospital employe to know what it is all about when the doctors start talking. As such, it deserves a well-thumbed place of its own on the library table; indeed, anyone interested in his hospital career should have and study a personal copy.

Barnett takes Columbia post; Cartmill advances at Harper

■ E. DWIGHT BARNETT, M.D., has accepted the post of professor of administrative medicine and the directorship of the Institute of Administrative Medicine in the School of Public Health at Columbia University, New York City. His successor in the position he has held since 1946 . . the directorship of Harper Hospital, Detroit, Mich. . . is George E. Cartmill, who has been associate director of that institution since 1949.

Dr. Barnett, who is a distinguished figure in the hospital field, has been active in all phases of progressive action. In 1950 he was named a Diplomate of the American Board of Preventive Medicine and Public Health, and in 1947 became a Fellow of the American College of Hospital Administrators. Since 1947 a member of the Blue Cross Commission of the American Hospital Association, he was made a member of the A.H.A. board of trustees last year. Past-president of the Michigan Hospital Association (1940-50), Dr. Barnett has been prominent in both Michigan Hospital Service and Michigan Medical Service.

George E. Cartmill is a graduate of Wisconsin State College, Stevens Point, Wis. (B.S. '38), and a veteran of Army service 1941-45. He holds the degree of M.S. in Hospital Administration from the School of Public Health, Columbia University, following an administrative residency under Dr. Barnett at Harper Hospital.

He was appointed assistant director, Harper Hospital, in 1947, becoming associate director two years later. The current appointment as director includes also the secretaryship of the hospital's board of trustees.

Mr. Cartmill is a member of the American College of Hospital Administrators, as well as a personal member of the Michigan Hospital Association and the American Hospital Association. He is chairman of the Council on Administrative Practice of the Michigan Hospital Association and president-elect of the Detroit Area Hospital Council.

The Department of Nursing Service is under the editorial direction of Dina Bremness, superintendent, Glenwood Community Hospital, Glenwood, Minn.

nursing service

How practical are practical nurse education programs?

By Florence Slown Hyde • Hospital public relations counsel

■ IN 1905 Mercy Hospital at Marshalltown, Iowa, established a nursing school with a one-year course. In due time this was changed to a three-year course to comply with advancing standards set up by nursing leaders.

After its school had graduated 232 nurses in its 43 years of operation, Mercy Hospital decided in 1948 to discontinue the three-year course for professional nurses and opened the "Mercedian School for Practical Nurses," with an 18-month course. In 1949 the State of Iowa passed a law providing for licensure of practical nurses who had completed a course of study of at least one year in an approved school of practical nursing or in an approved school of professional nursing or who could qualify under a waiver clause by taking an examination.

Miss Vera M. Sage, R.N., executive secretary of the Iowa board of nurse examiners, states that of 1,497 practical nurses licensed by examination prior to January 1, 1952, approximately 25 had completed one year's work in a professional school. Iowa is the only state that has a provision of this kind. Mercedian School, the only approved school for practical nurses yet established in Iowa, has graduated 41 students to date. Its present enrollment is 24, which indicates that its 18-month course attracts those who are interested in preparing for a nursing career.

The story of Mercy Hospital's conscientious effort to educate nurses to care for the sick is in the main the story of the evolution of nursing education over the last half-century. Although few hospitals, which found it difficult or impractical to maintain a three-year school in accordance with present standards, have thus far substituted a shorter program as did Mercy Hospital, many hospitals have found it desirable to establish practical nurse schools or cooperate with other agencies by providing the necessary clinical instruction and experience for practical nurse students.

Prefer 18 months . . Another significant fact about the Mercedian School is that the Sisters of Mercy are sticking to their original conviction that an 18-month course is preferable to a shorter course, although the Iowa licensure law sets 12 months as the required minimum. Following completion of the basic program of 12 months, Mercedian students receive six months of additional training in home nursing and experience in operating, labor and delivery rooms. Sister Irma, R.S.M., R.N., director of nurses in the hospital, is director of the school. She states that most of the graduates have positions in hospitals.

In addition to the advantages of a comprehensive course, Mercedian school provides maintenance throughout the course and, after the third month, an allowance of $10 per month is paid. There is a registration fee of $10 and students pay $75 for books, uniforms, etc., with a small additional charge for the diploma and school pin, presented at the conclusion of the course. Applicants must have at least two years of high school education and high school graduates are preferred. They may be either single or married and the age range is 17 to 40 years.

In striking contrast to the 18-month course at Mercedian School are the laws of 14 states which set nine months as the minimum length of the course in an approved school of practical nursing. However, some of these laws used the phrase "not less than nine months nor more than 12 months" and others leave the way open for state approving authority to determine the length of the course. With the exception of Massachusetts none of the states require a course of more than 12 months in an approved school for practical nurses or attendants.

The New York law prescribes a course of "not less than nine months," while 1951 regulations of the commissioner of education stipulate "not less than nine months nor

Practical nurse students . . assist in caring for mothers and babies at Mercy Hospital, Marshalltown, Iowa

more than 18 months with provisions for adequate clinical experience."

The "Minimum Curriculum and Syllabus for Schools of Attendant Nursing," issued by the approving authority in Massachusetts, prescribes a 15-month course but states that "the placement of topics is flexible and no fixed program for the course has been given." Emphasis is given to training for bedside nursing with at least 11½ months of practical experience in a hospital.

Prefer 15 months . . Massachusetts has 16 approved schools for nursing attendants which indicates that hospitals and other agencies have found a flexible 15-month program satisfactory. New York state with 17 approved schools of practical nursing is the only state having more approved schools offering this type of program than does Massachusetts.

The 15-month course offered by the Household Nursing Association in Boston, with the cooperation of several hospitals, including Massachusetts General, provides six weeks of preliminary training at the Practice House of the Central School, followed by 13 months' experience and clinical instruction in a hospital, two weeks of which are allowed for vacation. Following completion of the hospital training, students return to the Practice House for two weeks of special training for home nursing.

On completion of the 15-month course the graduate devotes 24 weeks to actual practice in private homes under the supervision of one of the staff nurses of the Household Nursing Association, who taught her during her course at the Practice House. Cases are chosen by the registry of the association to give her as varied experience as possible and she receives wages from the patients just as she would in private duty nursing on her own.

Tuition for the 15-month course is $120 for students who have lived in New England at least two years. Tuition for students outside New England is $140. Enrollment fee, uniforms and other equipment cost $60. Students receive room, board and laundry during the entire course. In addition they receive allowances of $15 a month for the first nine months at the hospital and $30 a month for the remaining four months. The age range for admissions to the school is 18 to 50 years.

In this connection it may be noted that Massachusetts has lowered the age for licensure of attendants from 20 to 19, thus making it possible for students who enter training at 18 to become licensed soon after graduation instead of waiting several months to reach the required age. Several other states would do well to look into the inconsistency of the licensure age in relation to the minimum age for admission to schools for practical nurses or attendants.

Accredited schools . . Accredited schools include two programs given by the University of Minnesota, five programs offered jointly by public school systems and hospitals and six schools maintained by hospitals. Among the hospital schools is that of the Charles T. Miller Hospital in St. Paul, whose administrator is Dr. Peter D. Ward, former president of the American Hospital Association.

The Charles T. Miller School of Practical Nursing offers a 12-month course, which includes a 28-day affiliation in home nursing under the direction of the Family Nursing Service in St. Paul. An introductory period of 13 weeks is followed by 37 weeks of clinical instruction and experience, including 17 weeks of medical and surgical nursing during which some advanced procedures are taught to students, such as the taking of blood pressure readings. Four weeks each are given to obstetrical nursing, care of the newborn, pediatric nursing, psychiatric nursing and, as mentioned above, home nursing, with two weeks allowed for vacation. Teaching hours total 475 with 190 hours devoted to nursing arts.

Classes are admitted in January and September. The present enrollment is 41 and graduates to date total 139. Of the graduates, 52 are on the staff of Charles T. Miller Hospital, nine are employed in other Twin City hospitals, 18 are employed in rural Minnesota hospitals and two in V-A hospitals outside the state. Five are on the staff of the Family Nursing Service in St. Paul and Community Health Agency, Minneapolis, 10 are employed in doctors' offices, one in a clinic and one in private duty. Three have entered three-year nursing schools, two are taking an x-ray course, one has entered a teachers college, four are working in other fields, 26 are married and not working, and one is deceased.

Miss Thelma Dodds, R.N., director of nurses, states that the Charles T. Miller school of practical nursing was started because of the need for

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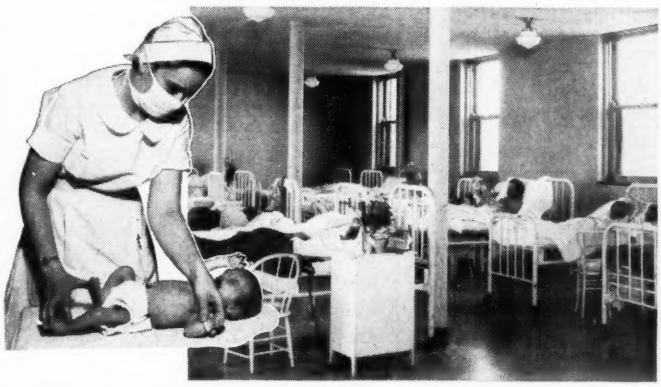

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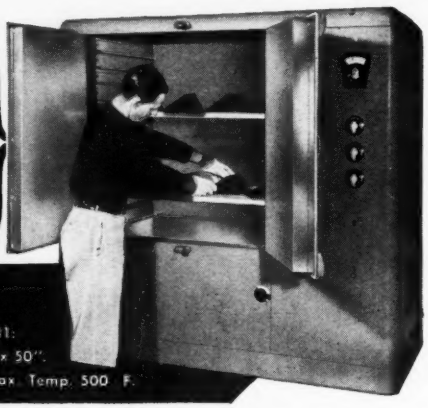

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Care of the aged . . is included in the course of the Charles T. Miller Hospital School of Practical Nursing at St. Paul, Minnesota

this type of worker on the hospital's health team and that they "now know that practical nursing is an essential service in the care of the sick."

Students must be between 18 and 35 years of age. High school graduates are given preference but no specific subjects are required. School fees and expenses paid by the student total $50. Board, room, laundry, books and uniforms, with the exception of white shoes and hose, are provided by the hospital.

Minnesota schools . . Schools in Minnesota have been given a choice of offering a nine-month or a 12-month course, since the law in that state prescribes a course of not less than nine months. However, the most recent list of 13 accredited schools of practical nursing issued by the state board of examiners of nurses includes only one school with a nine-month course and one with a 10-month course, the latter planning to change to one year soon. The others have 12-month courses.

Another Minnesota school which is serving its community admirably is maintained by Union Hospital at New Ulm. It was established in 1945, continuing a course sponsored jointly during the war by the local high school and the hospital. Following the adoption of the practical nurse licensure law in Minnesota it was

accredited by the state board. Its more than 100 graduates are employed mainly in the home hospital or nearby rural hospitals. Some are employed in doctors' offices.

Miss Esther Ida Stephan, R. N., director of the Union Hospital school for practical nurses, reports that 17 students entered on September 10, 1950 and all were still in the school on January 17, 1952. High school graduates are preferred as students. Board, room and laundering of uniforms are provided by the hospital, plus a stipend of $10 per month for the first three months, and $30 a month thereafter. Students pay an enrollment fee of $5 and $10 for textbooks. They provide their own uniforms and other equipment.

Following a two weeks' preliminary period of classroom instruction, each student receives duty assignments of 32 to 35 hours per week under guidance and supervision of registered nurses, with two to three hours of class work each day. The last two months are devoted to experience employment in the hospital.

How do YOUR nursing costs compare with those on page ten ?

Editor's note—Information about state regulations and programs of individual schools for practical nurses, in other states, the curriculum and standards advocated by nursing and vocational education leaders, and other facts of interest about practical nurse licensure and education will be presented in a future article.

WHOLESALE THERAPY

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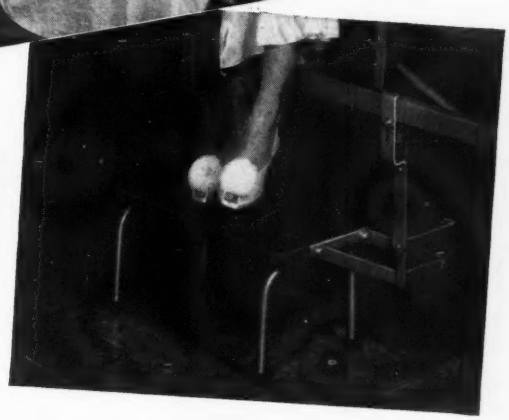

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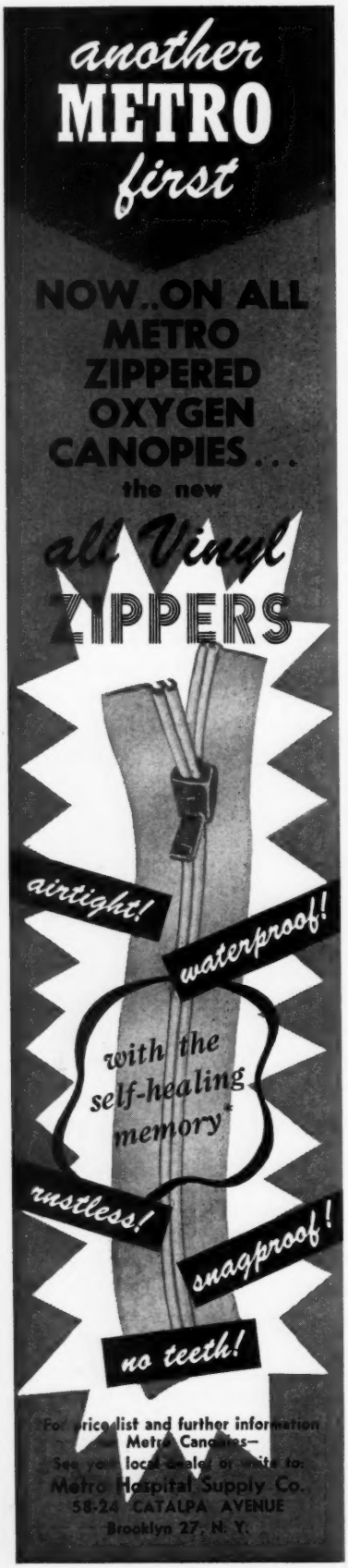

Status of the practical nurse in patient care today

by Elizabeth Turnbull
Coordinating Instructor
Vocational Nurse Education
Marina Adult School
San Francisco

■ THE CONCEPT of the practical nurse is not a new one. Adelaide Nutting advanced the idea of creating a second level nurse and again in the Goldmark report, published in 1923 under the title "Nursing and Nursing Education in the United States," the statement is made that a definite need existed for a cheaper and less highly trained nurse. More apparent at the present time than ever before is the need for a properly prepared practical nurse.

Since the supply of professional nurses does not meet the demand, nor is there any prospect that the supply of professional nurses will become adequate in the near future, and in order to provide the kind and quality of nursing care that society needs at a cost which is not prohibitive, the professional nurses are attempting to meet their responsibilities of nursing care by sponsoring practical nurse programs. These programs are being set up mainly in educational institutions as a part of the public school system.

Within a short period of time the number of prepared practical nurses has increased markedly and recognition has been given to them at local, state, national, and international levels.

The needs of society for total nursing care . . The ever changing and expanding needs of society for medical and health care have intensified the realization that another group of nurses, namely the licensed practical nurse, must be prepared to assist the professional nurse if adequate nursing care is to be given all. It is not so much a question of shortage of nurses in actual numbers since there are more nurses in active service today than ever before, but the functions of nursing are changing radically and are becoming more and more complex. Some of the factors which have placed greater demands upon nursing and which are due, no doubt, to the changing emphasis in medical care of today are as follows:

1. There is more and more importance placed on preventive medicine, necessitating different types of personnel with need for conscientious team work.

2. The actual duties of the professional nurse have been greatly expanded. Due to the advances in the field of science the nurse must perform many of the duties formerly carried on by the medical men themselves. To illustrate this, consider how the universal use of blood banks has notably increased the number of transfusions, the administration of which have been given over frequently to the nurse.

3. Industry is using the services of nurses in an ever increasing amount.

4. Chemotherapy with the introduction of the antibiotics has added to the complexity of the nurses' work.

5. Early ambulation of the obstetrical and surgical patients means more rapid turnover of patients, with an increase in the number of patients who can be cared for in hospitals, which results in a greater and greater load on the nursing staff.

6. The increase in the life span means that the number of the aged in the population is greatly increased. This means there are greater numbers today with various degenerative diseases needing nursing care than there were ten to fifteen years ago.

Aside from these factors, there have been socio-economic changes which have increased the nursing load to such a degree that it is imperative that another group be prepared to assist the professional nurse. For example, there is the prepaid hospital and medical care insurance which makes it possible

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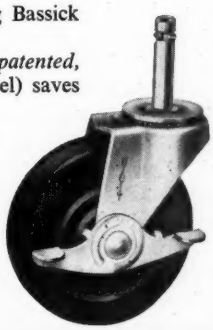

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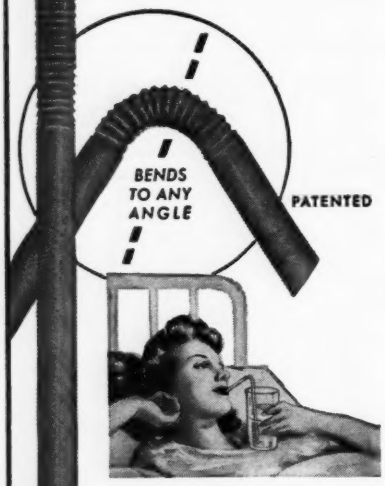

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for an increasingly large proportion of the population to receive hospital care through economical prepaid plans. Many new hospitals are being constructed under the Hospital Survey and Construction Act. This means increased numbers of patients with a consequently increased need for more nurses.

Again, the ranks of the professional nurses have been depleted greatly by the demands of the Veterans Administration, military service, and the withdrawal of numerous graduate nurses who are furthering their education under the G. I. Bill of Rights. When you consider these numerous changes, it is easily understandable that a second level nurse must be prepared to relieve the professional nurse of less demanding duties so that the professional nurse can assume the responsibility of these procedures demanding a higher degree of technique and skill.

Educating the practical nurse . . The second level nurse is being educated not to supplant the professional nurse but only to assist the professional nurse as a member of a nursing team in situations in which she has the closest supervision. Her place within an integral team may be in homes, hospitals, public agencies or doctors' offices.

At present there are three general types of institutions offering programs for practical nurses: namely, hospitals, private schools and vocational schools. In a study carried out by the National League of Nursing Education's department of studies in 1949 there were found to be 179 organized training programs for practical nurses in the United States and its territories. Of this number 103 were conducted under vocational education auspices.

The vocational school program for practical nurses is organized within the framework of the educational system administered under both state and local boards of education. This type of school enjoys many advantages not always true of other types of teaching programs: namely, adequate teaching facilities, equipment, prepared faculty and necessary funds.

Curricula . . The typical school has a twelve-month program composed of three months of classroom instruction in nursing techniques and related problems and followed by nine months clinical experience in an accredited hospital.

The curriculum constructed on the basis of the job analysis under sponsorship of the United States Office of Education is a valuable guide for instructors responsible for the education of practical nurses. It deals with subject matter and terminology on the practical nurse level. The situation approach is adopted in the teaching rather than the factual subject matter approach.

Selection and admission of students . . Admission requirements vary in the different schools. Usually the education requirement is two to four years of high school. Additional requirements include good health, physically, mentally and emotionally; good moral character; and ages between 18 and 55.

Tests to be used as an aid in the selection of students for practical nursing have been set up by the department of measurement and guidance of the National League of Nursing Education.

Financial support . . The vocational school program for practical nurses can be financed by the Federal government through the Smith-Hughes and George-Barden Acts and also from state and local funds. Because these schools are supported by public funds it is not necessary to require tuition.

Accreditation . . The approval of schools of practical nursing is being assumed at present by the state board of nurse examiners in at least 18 states but this approval is not to be confused with real accreditation. The National Association for Practical Nurse Education offers advisory services for developing and accrediting practical nurse programs. The National Nursing Accrediting Service, which is responsible for accrediting all professional nursing programs, plans in the near future to include in its activities the accreditation of practical nurse programs.

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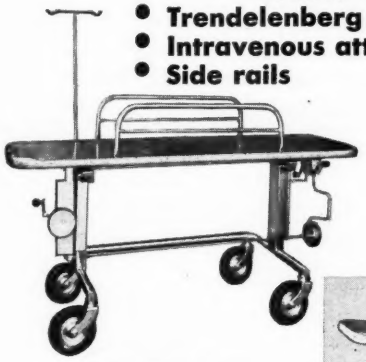

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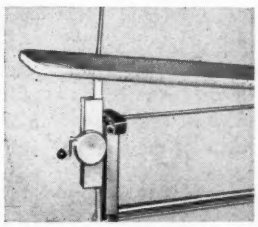

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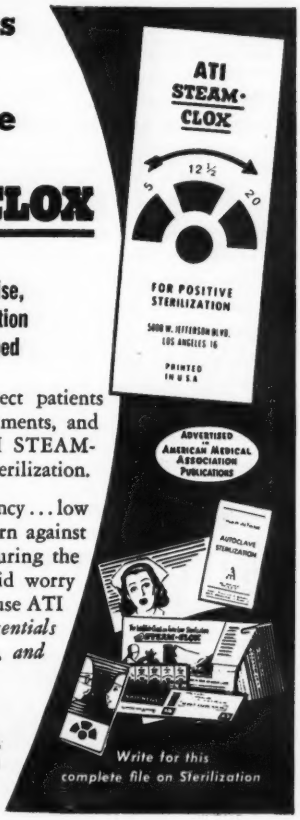

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and experience vary considerably for instructors of practical nurses. However, it is agreed that the instructor in practical nursing be a professional nurse holding a degree and teaching credentials. She should have a thorough knowledge of her subject matter and possess the ability to teach.

Licensing—mandatory and permissive . . In May 1951 twenty-nine states and two territories had laws governing the training and licensure of practical nurses. Five of these have mandatory laws which stipulate that all who nurse for hire must be licensed. All others are permissive. Within the past few months California has passed a permissive licensing act for practical nurses. In this act the term "practical nurse" has been changed to "vocational nurse." Because of the many poor and unprepared people who use the title "practical nurse" this change of name is welcome and gives to the practical nurse group a more definite status and dignity heretofore not possible.

Meeting the need . . The Michigan practical nurse program is outstanding. Under the joint sponsorship of the State Department of Public Instruction, through its Division of Vocational Education, the Michigan practical nurse program was instituted in 1947 through a generous grant by the Kellogg Foundation for experimental work on a state wide basis.

Graduates have contributed a distinct and substantial amount of nursing service as is indicated by the following figures: 74 per cent have worked all or most of the time since graduation, 18 per cent have worked some of the time, and only 8 per cent worked none of the time. Eighty-three per cent were employed in hospitals, 10 per cent in private duty nursing, 3 per cent in convalescent homes, and 4 per cent in other types of nursing: namely, doctors' offices, public health agencies and employment as children's nurses.

There was found to be considerable stability of employment, most of the graduates reported as remaining in one type of employment and only a few had changed from one type of employment to another.

Here in California, the professional nurses are making great strides in planning and working toward a better prepared practical nurse. Principles for a sound and workable curriculum have been formulated by the members of the California League of Nursing Education.

It is regrettable that it is not possible to quote exact figures on a state wide basis since responses to recent questionnaires mailed to schools of practical nursing had not been received at the time of the writing of this paper. (See page 81.) It may not be amiss to state what is being done in San Francisco at the Marina Adult School.

This program is sponsored by the League of Nursing Education and is offered by the adult division of the San Francisco Public Schools administered by the Marina Adult School.

The program is one year in length divided into six months of class room instruction and laboratory practice, and six months of clinical experience given either at Stanford University Hospital or the San Francisco Hospital. Throughout the course, even while affiliating, the student is considered a member of the San Francisco Public Schools and upon completion of her course receives a certificate in practical nursing from the San Francisco Board of Education.

The school department has employed six qualified nurse instructors who also hold their teaching credentials to instruct in this program both at the school and in the hospitals. Recently, a nutritionist has been added to the faculty.

The committees functioning in the interest of the program are:

1. The advisory committee composed of representatives of local groups interested in nursing, community health and welfare, who make recommendations relative to the program and establish good public relations.

2. The steering committee whose functions are to advise and make recommendations relative to maintaining educational standards and formulating policies.

3. The screening committee composed of representatives from the

school, the two hospitals and a nurse educator who review applications and credentials of applicants and also review the achievement records of those students whose grades are in the lower rank to determine whether or not they shall be permitted to complete the course.

In response to a questionnaire sent to the graduates of the first two classes it was learned that 86 per cent were working and utilizing their training, the majority of these being employed in institutional work. All but three of these graduates have remained in their first position since completing the course, indicating that they can be counted on as a steady source of service.

The students enrolled in the fall class were given the tests standardized for selection of students in practical nursing by the department of measurement and guidance of the National League of Nursing Education.

The graduates of this school have an active alumnae association which meets monthly to consider problems of personal relationships, nursing problems and to consider ways and means of increasing recruitment.

This practical nurse education program was inaugurated Nov. 1, 1948. There have been 102 graduated, two of whom were men. Enrolled at present are 105 students at the school, 16 students in clinical experience at Stanford University Hospital and 29 at the San Francisco Hospital.

It is regrettable at the present time that many, including graduate nurses, are hesitant about permitting the practical nurses to do all the procedures they are being taught. This has been discouraging to the practical nurse graduates. Also disturbing to them is the fact that some of the hospitals do not permit them to wear their uniforms of which they are very proud. These dissatisfactions no doubt add to the recruitment problems.

That the medical profession is in sympathy with the use of this second level nurse has been demonstrated in the interest they have taken in the program at the Marina Adult School. The doctors have been instrumental in recommending many of the applicants to this course. It is most encouraging to see the increased numbers of local hospitals requesting graduates.

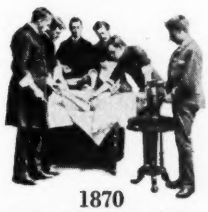
Conclusion . . In conclusion, there is no doubt that the demands for nursing service are increasing both quantitatively and qualitatively; that the functions of nursing are changing and becoming more complex and the solution for meeting the needs of the people for nursing service is the education of this second level nurse to work as a member of a team with the professional nurse. ■

Income-expense imbalance

■ DURING THE LAST five years, short term hospitals in the United States have been obliged to spend $1,343,000,000 more than they received from patients, reports the A.H.A.

■ DURING MEDIEVAL TIMES, the city of Florence (in what is now Italy) could boast 30 hospitals with a total of over 1,000 beds. This average . . at least one bed for every 100 inhabitants . . is a better showing than most modern cities can make.

One of a series currently appearing in leading surgical journals.



1870

"Antiseptic" surgery during the reign of the carbolic spray. From a rare old photograph. Courtesy of The Bettmann Archive.

THE FIRST year of Gudebrod's long history of specialization in the manufacturing of fine silk for sutures was way back in 1870. Gudebrod's sewing silk was widely used for suturing until the turn of the century when the first silk sutures, labeled "Surgeon's Silk," were introduced by Gudebrod.

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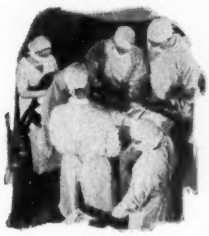

1952

The transition from the "antiseptic surgery" of 1870 to the aseptic technics of 1952 is just one of the many forward strides of modern surgery.

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New personnel programs . . Comer

continued from page 42

Members of the medical staff can create unusual and ticklish problems which can rupture good personnel relations. What is your cue if a surgeon flings a hemostat at a nurse just as you pass the operating room? Or what will you do if a physician scolds the telephone operator so roundly that she quits? These are not, of course, situations which arise with any frequency, but they do happen occasionally when an M.D. begins to believe that the medicine man is made of more exalted stuff than the rest of the tribe. Fortunately, very few of the staff ever develop these superiority complexes, and their actions will not make them popular with their fellows.

Your basic responsibility is to build harmonious relationships among employes, and you must not be afraid to take the employe's side in an employe-physician argument if the employe is in the right. The physician may be able to exert enough pressure to force you to resign, but you would have to leave anyway as your program deteriorated because of loss of employe respect.

Politicians . . Local politicians can be quite a thorn in the flesh, since almost every hospital needs the good-will and support of the so-called "civic" and political leaders. Some hospitals are almost immune from these petty irritations, while others are tortured constantly by the slings and arrows of greedy men who use every source they can find to bolster their own political futures.

To get to the bare facts of this situation, politicians' principal aim is to make people believe that favors follow on the heels of loyalty. Thus, some will win the support of a potential voter by obtaining employment for him or a member of his family. Since most of the persons who use such an employment "bureau" are from lower-income families, the ward heeler will suggest that they try to "get on at the hospital" as an orderly, janitor, kitchen helper, or attendant. Every vote counts and a satisfied customer is a voter, so you may be asked to "consider" various jobless people "recommended" for openings in the hospital.

Very few politicians follow up on their clients to see whether they really obtained employment or not, for they have already won the support of the person by conspicuously attempting to get him a job. Your best defense against having to hire an individual who is totally unsuited for the job is to establish fairly rigid job requirements. You can then, with great deference, explain why you could not hire the person. Most politicians will understand that you cannot put a round peg in a square hole and very few will be critical of you for turning down a misfit . . for you are a rather influential voter, too!

Do not, however, make a practice of turning a deaf ear to all people who are referred by politicians,

Stryker

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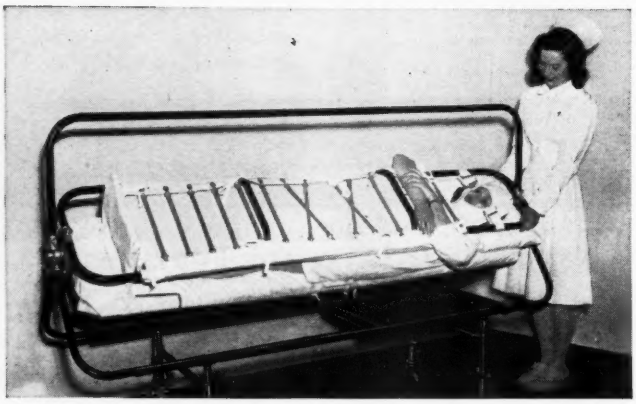
In immobilization, the smallest nurse can turn the largest patient with utmost ease and safety.



A new development in the treatment of immobilized patients, the Stryker Turning Frame is essential equipment for the modern hospital. While held gently but firmly between the two frames of this unique device, any patient can be quickly turned by one nurse. One frame is removed after turning, and the other, covered with taut canvas and pad, provides a smooth, comfortable resting surface. Lying on the anterior frame, the patient can read, write and feed himself with ease. In cases of pelvic, intertrochanteric or cervical fractures, either end of the frame can be elevated to provide continuous traction throughout the turning process. Built of the finest materials, and widely accepted by orthopedists, gynecologists and neuro-surgeons, the Stryker frame saves valuable nursing time and increases the comfort and well-being of the patient.

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though, for many excellent employes are obtained through this medium. No source of personnel should be overlooked or alienated, but people referred by community leaders ought to be very carefully screened to weed out those who are not suitable, because it may be very difficult to dismiss them later. When you do hire a person recommended by a local official, tactfully tell the "referring agency" that you hired the person on his *merits* and add that you are always eager to learn of *qualified* persons who are seeking employment.

"Brass tacks" . . 1. Learn the general plan of hospital service and how the various departments dovetail into the over-all plan.

2. Meet both department heads and employes . . being careful to watch for personality patterns and friction between people or departments. Avoid creating the impression that you are going to change things radically. Be friendly, warm, and impartial.

3. Watch for a trouble spot and begin your operations with this problem. You will be most fortunate if a department is having trouble and your help is welcomed. Be discreet and guide . . rather than direct . . the changes you think might clear up the difficulty. Ideas always seem sounder if we think of them ourselves, so try to have suggestions come from the group. Other departments will watch you with interest and if you are liked by the troubled department you will find your popularity spreading.

4. Do not take over the screening of personnel for any department until the department head asks for your help. Most people dislike the chore of interviewing candidates, and, department by department, you will eventually centralize the screening of personnel.

5. Start to codify personnel policies and rough out an employe manual. Take your time about this, though, for it is unwise to publish an employe manual until you have been on the job long enough to see all sides of the picture. ■

Baumgarten given Blue Cross post

■ ON JANUARY 1, Harold Baumgarten, Jr., became manager of the Hospital Relations Division of the Blue Cross Commission. He will maintain liaison with the A.H.A. on matters of mutual concern to Blue Cross Plans and the hospitals.

Mr. Baumgarten has had more than three years' experience as administrator of hospitals in Oregon and Idaho and a year and a half as director of hospital relations for Idaho Hospital Service, the Blue Cross Plan located in Boise.

He has a B.S. degree in institutional finance from Willamette University, Salem, Ore., and studied at Reed College, Portland, Ore., where he was enrolled in graduate courses; he has served as president of the Eastern Oregon Hospital Council and Southeastern Idaho Council secretary, and executive secretary of the Idaho Hospital Association.

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HAPPIER NURSES • STEADY INCOME!
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the hospital pharmacy

Manufacturing in the pharmacy

by **Allen V. R. Beck** • Chief Pharmacist • Indiana University Medical Center • Indianapolis, Indiana

■ THERE ARE MANY FACTORS affecting a manufacturing program in any hospital. Let us consider a few points to be checked and evaluated before a manufacturing program can be developed or carried out. The prices used in this paper are our own whether they be too low or too high.

The simplest form of manufacturing is the extemporaneous compound of a prescription. Every pharmacist has done manufacturing to a limited extent. The hospital pharmacy offers perhaps the best outlet for privately manufactured products. The extent to which any hospital can manufacture depends upon three main factors, namely:

1. Size of the hospital.
2. Type of hospital.
3. Presence of an outpatient department.

1. The size of the hospital will directly determine to what extent manufacturing can be carried out. This is only a quantity extent, not the varieties involved. A small hospital can manufacture just as many items as a large hospital but of course the batch sizes will be considerably smaller.

Bob Cathcart, chief pharmacist at the Chester County Hospital located in West Chester, Pennsylvania, has a hospital of about 125 beds. This hospital pharmacy manufactures almost all of the items used within his hospital from sterile parenteral solutions to the simplest pharmaceuticals. In fact, Bob manufactures about twice as many items for his 125-bed hospital as we do at the medical center with 650 beds, but our batches on each manufactured item are much larger.

2. The type of hospital determines the type and quantities of products to be manufactured. This point is very distinctly brought out in our own campus where we have an ob-gyn hospital, pediatric hospital, and an adult, medicine and surgery hospital. Coleman, the ob-gyn hospital, uses very few pharmaceuticals, and those in limited quantities, while Riley, the pediatric hospital, uses tremendous quantities of biologicals, antibiotics, and special formulations.

Long, the adult medicine and surgery hospital, uses what seems to be carload lots of every item carried in our pharmacy. To further show the effect of type of hospital on the varieties and quantities used, let us compare a private non-teaching hospital to a state, or city, operated hospital with a teaching staff.

The private hospital is taking care of the patients that their staff sends to the hospital. Each case is different and handled in a different way by the physician. This practice tends to use small quantities of numerous different pharmaceuticals, each of which is ordered out of the pharmacy for each individual patient. The orders filled by the pharmacy are numerous and small. A pharmacy of this type will have many duplications of therapeutically equivalent items.

The teaching institution maintained by the state, county, or city usually has a greater variety of patients from a more widely spread area than the private hospital does.

Our particular units offer hospital service to the welfare and indigent people of the State of Indiana. Our staff is made up of men who are trying to teach medical, dental and nursing students. For these students to have an adequate background they must be able to see many varied types of patients as well as see the effects of different pharmaceuticals upon these patients. Expense, in this type of institution, is sometimes overlooked merely to provide the staff and students with a good teaching case.

3. The presence of an outpatient department, or outpatient clinic, determines greatly the quantities of pharmaceuticals manufactured, as well as standardization of these pharmaceuticals. A hospital with an outpatient department serving 300 people a day is just supplying 300 more people a day than the pharmacy would otherwise service. This important factor greatly influences a manufacturing program.

Any hospital can manufacture its own products regardless of size or type if a concerted effort is made. Perhaps the main reason for manufacturing your own pharmaceuticals is to reduce the per unit cost. This is entirely possible but do not forget another important reason, namely, to provide the hospital with good pharmaceutical products that have not appeared on the market or provide products that more closely resemble the product desired by the staff.

There are many items that the pharmacy can manufacture that are

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With AGORAL*, there is no forcing, griping pains or anal seepage.

Effective, pleasant in taste, and readily miscible with foods and beverages, AGORAL* is the ideal laxative for young and old alike.

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not pharmaceuticals, such as ink, electrode paste and deodorant cubes. To have any manufacturing program succeed, or any program succeed, the whole-hearted and complete cooperation of the physicians, nurses, and administrative staff is required.

Perhaps the most effective organization or group to back and promote a manufacturing program is the therapeutics or pharmacy committee. This committee can give great assistance to the pharmacy in choosing items to be manufactured. This committee can often secure the aid of other department heads to determine the products most acceptable to the staff and patients.

Requirements . . Just what equipment, space, and personnel are required for a manufacturing room? The size of the equipment is determined by the batch sizes your particular hospital can use in a reasonable length of time. The space required is directly proportional to the size and amount of equipment purchased. Personnel requirements for manufacturing are determined by the quantity and scope of your manufacturing. Always be sure that all your manufacturing is carried on under the direct supervision of a registered pharmacist.

Let us return to the question of what equipment is required.

I will consider only eight pieces of machinery.

1. First of all, a pharmacy needs a ready source of good distilled water. Purchase a still that is too large, then distilled water is not a factor to slow down your production.

2. A stainless steel mixing tank of appropriate size with a variable high speed agitator is required.

3. A liquid handling pump or filter press. There are several products on the market that will perform both jobs.

4. A storage tank of desired size, preferably a glass lined, or stainless steel tank.

5. Large capacity balance.

6. A small mixing device between hand mixing and the tank listed as No. 2.

7. Ointment mill of some type, either the grinding or roller type.

8. A colloid mill of adequate size.

Equipment . . Here is a list of our equipment corresponding to those just mentioned, along with our actual cost.

1. Still—A Barnstead 20 gal. per hour automatically controlled still with a 100 gallon storage tank. Installed in the pharmacy $1,400.00

2. Mixing tank with agitator—A 30 gallon stainless steel, type 304, tank with a lightning C-V-4 agitator $185.00

3. Filter press or pump—An Alsop Hi-Speed filter press of stainless steel, portable mount, with acid proof hose $340.00

4. Storage tank—A 30 gallon glass lined Pfaudler tank on stand .. $85.00

How do YOUR pharmacy costs compare with those on page ten ?

5. Large balance—Howe balance 100 pound. Capacity 4 gm sensitivity $280.00

6. Small mixing device—Hobart mixer, 5 gallon capacity with a set of attachments for working 3 gallon quantities $230.00

7. Ointment mill—A J. H. Day roller mill having 5 inch by 7 inch rollers that are water cooled $1,200.00

8. Colloid mill—A Charlotte colloid mill with stainless steel contact points $640.00

The total expenditure for this equipment is $4,360.00

With this investment of roughly $4,300.00 you have the nucleus for a manufacturing room. Of course the hospital authorities are always hesitant about spending a sum like this unless they can get some percentage return on their investment.

Pay dirt . . Let us see if we can find an item to pay for the still, storage tank, and liquid handling pump or filter press. More and more hospitals are using zephiran chloride solution 1:1000. The purchase price per gallon, in five gallon lots, is $3.48. When the zephiran concentrate, costing $17.04 a gallon is used, the cost of one manufactured gallon of the zephiran is 13¢ for the concentrate and allow 5¢ per gallon for the distilled water.

These two figures added together make a total cost of 18¢ per gallon, or a net savings of $3.30 per gallon. This is not a large savings on each gallon, but when a quantity like 25 gallons a day, seven days a week, is consumed, the weekly savings on zephiran is $577.50 or enough to pay for, or amortize, the equipment investment of $1,825.00 in only three weeks.

You may ask why the pump and storage tank in this particular setup. A good question. When the quantity of zephiran used is very large, the labor time involved in making up each gallon individually is too costly. In fact it will almost discourage the manufacturing of this item in favor of purchasing the ready made solution. The use of a tank merely cuts the labor cost per gallon by $30. A side note in using a tank for zephiran storage: if you put in the concentrate first and then pump in the water, the tank is almost half full of foam, while if the water is pumped first and then the concentrate you must manually stir the liquids. Put in the concentrate and pump the water in through the draw-off faucet of the tank. This method causes no foam and mixes the two liquids.

Now let us see if we can find a product to manufacture so that we can purchase the mixing tank with high speed agitator. Milk of magnesia is a product used by almost all hospitals. Clark Whittacker and Daniels of New York have available a hydro-magma paste to which is added distilled water, oil of peppermint and citric acid. When these four ingredients are mixed together at high speed a very satisfactory milk of magnesia is produced.

The cost of one gallon of this product is 25¢ including labor charged out at two dollars per hour per person. The milk of magnesia available on the open market costs about $1.00 per gallon in 48 gallon quantities. By manufacturing our own product we have saved a total of 75¢ per gallon. On a year's sup-

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in practical, convenient and economical forms for every hospital service, the following antibiotic agents are now available with the *Pfizer* seal of purity, potency and quality...

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100 mg., bottles of 25 and 100
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Oral Suspension
Vial containing 1.5 Gm.; bottle of 1 fl. oz. special raspberry-flavored, non-alcoholic diluent

Elixir
Vial containing 1.5 Gm.; bottle of 1 fl. oz. flavored, buffered diluent

Oral Drops
Vial containing 2.0 Gm.; bottle of 10 cc. flavored, buffered diluent; calibrated dropper

Intravenous
10 cc. vials containing 250 mg.
20 cc. vials containing 500 mg.

Troches
15 mg. each; boxes of 24

Ointment (topical)
½ and 1 oz. tubes; 30 mg. per Gm.

Ophthalmic Ointment
⅛ oz. tubes; 5 mg. per Gm.

Ophthalmic Solution
5 cc. dropper vials; 25 mg.

Otic Solution (with Benzocaine)
5 cc. dropper vials; 25 mg.

Nasal (with desoxyephedrine HCl)
5 cc. dropper vials; 25 mg.

Soluble Tablets
50 mg. each; boxes of 24

Vaginal Suppositories
100 mg. each; cartons of 10

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Pronapen* (Penicillin G Procaine Crystalline with Buffered Penicillin G Sodium Crystalline)
Penicillin G Potassium Crystalline
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Penicillin G Procaine Crystalline for Aqueous Injection
Penicillin G Potassium Crystalline Tablets (buffered)
Penicillin G Potassium Crystalline Soluble Tablets
Penicillin G Potassium Crystalline Troches
Pen-Drops*

STREPTOMYCIN

Streptomycin Sulfate

POLYMYXIN

Sterile (parenteral)
Sterile (topical)

DIHYDROSTREPTOMYCIN

Dihydrostreptomycin Sulfate
Crystalline Dihydrostreptomycin Sulfate Solution

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(Penicillin and Dihydrostreptomycin in a *single* injection)
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ply of 1,000 gallons the net savings is then $750.00. Once again we have amortized the equipment investment of $185.00 in the short time of only three and one-half months.

Example . . The next two items on our equipment list include a large balance and a small mixing device. The cost of this equipment is $510.00. A product that can be manufactured using both these pieces of machinery is tooth powder. Labor saved is going to be the only savings effected. Our old method of making tooth powder was to weigh out the small quantities of ingredients, work them up by hand in a mortar and pestle, and pour out. Using that particular method about 15 hours labor were required to make 40 pounds of tooth powder.

By using our large balance and letting the Hobart mixer do the work our present labor cost is only $4.00 per 280 pounds of tooth powder. This means a savings in labor costs of $206.00. On a year's total of about 1,000 pounds the total labor saved was $800.00, or one and two-thirds the cost of the equipment involved.

The second most expensive piece of equipment purchased, and used primarily for ointments, the roller mill costing $1,200.00, must be justified. This roller mill will work almost any type of ointment. Let us try to manufacture a chlorophyll ointment. The commercially available product costs $8.00 per pound. To make our own ointment a chlorophyll hydro-alcoholic soluble solution is purchased from Magnus, Maybee and Reynard for $6.67 a pound, or approximately 3¢ per cc. A base that can be used is carbowax 1500 costing 67¢ a pound.

Adding ingredient costs with the labor costs the final product should not cost you more than $1.40 per pound. On a year's supply this means a savings of about $1,000.00 on this one ointment. The roller mill cost is amortized in 14 months, if we manufacture only this one ointment. Don't forget the many other ointments that are used in the modern pharmacy.

The colloid mill is a valuable asset to any pharmacy. With a machine of this type emulsions and suspensions are much more easily manufactured. When making an emulsion of sulfadiazine the manufactured cost is only $8.00 per gallon while the list purchase price is $33.00 a gallon. On a year's total of 40 gallons there is a net savings of $600.00 or 93% of the cost of the colloid mill.

The business picture . . Now let us look at our picture from the usual business equipment amortization period of five years. We have spent a total of $4,360.00, and in five years the savings on the five items discussed would amount to over $162,895.00 or roughly 40 times the equipment investment.

Some of you here are saying, 'I cannot save that much money because my particular quantities are much less.' Do not be afraid to sit down with pencil and paper to figure out just what your requirements are each year and regulate your equipment size to meet those requirements. Smaller equipment costs less money. A smaller roller mill can be purchased for about $500.00 while the other machinery will decrease in price accordingly. For manufacturing many ointments the concentrated base can be worked by hand and then the Hobart mixer used as a pony mixer. This procedure can often eliminate the purchase on any ointment or roller mill.

You say that $4,300.00 is too much for you to invest in equipment. All right, let us work out the equipment for use on a much smaller scale.

Smaller scale . . The type equipment to be purchased will be the same, only smaller with less capacity. This equipment will not necessarily reduce the labor costs involved.

1—The Hobart mixer will remain intact costing $230.00

2—Instead of the semi-automatic bottler that has been mentioned, let us purchase some Hagerty handy fillers $25.00

3—Instead of the 100 pound balance let us use a 10 pound balance costing $100.00

4—A hand homogenizer costing $25.00

5—Instead of the automatic still, convert, by repiping, an old water sterilizer. This conversion will cost about $75.00

(Do not forget to get a permit to make a still as well as use one.)

6—The storage tank can be replaced by five gallon glass bottles costing about $1.25 each $6.25

This is a small manufacturing room with an investment of only $460.00. This set-up is capable of producing many varied types of pharmaceuticals of a quality equal to the larger set-up.

Expansion . . After a manufacturing program has been installed on a small scale, the time comes when the entire day is filled with necessary manufacturing. This presents a problem when expansion of the manufacturing program is considered . . how to manufacture more items when you are completely busy at the present time. This can be done by either of two methods:

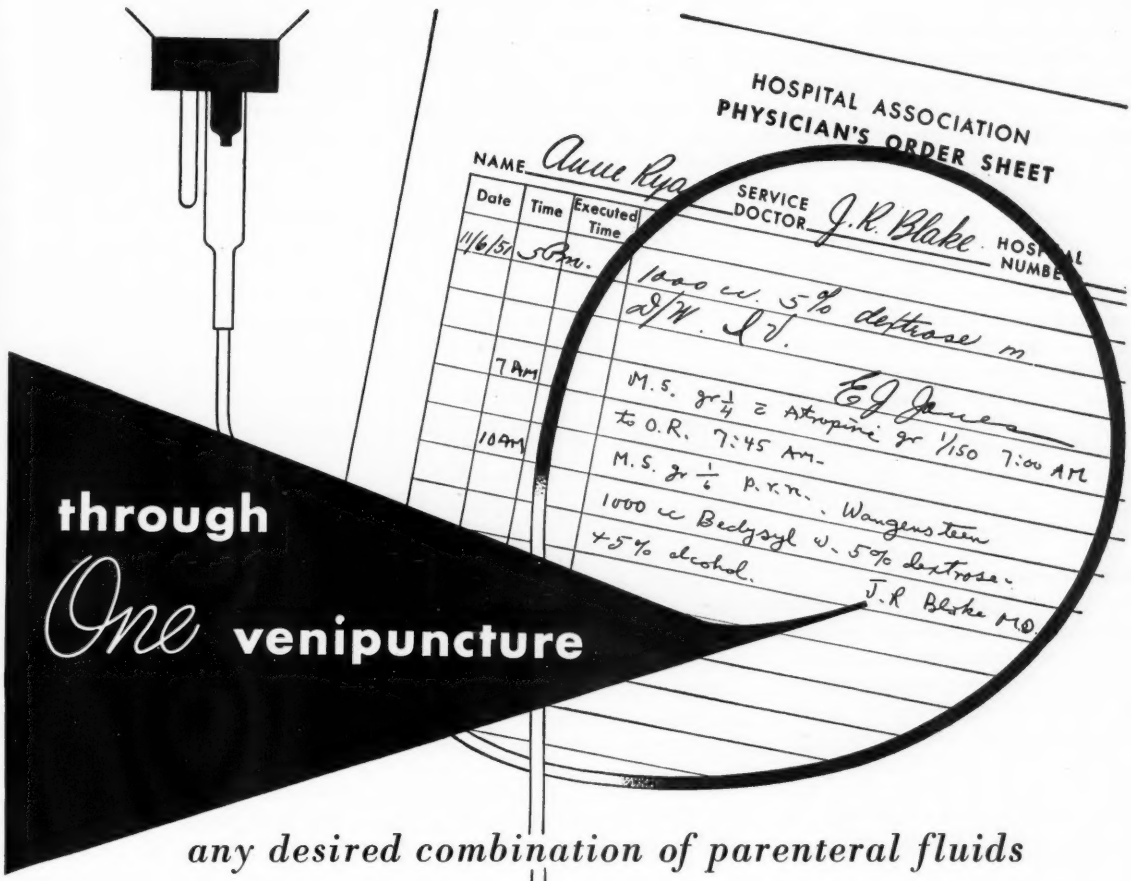
1—Decrease the time spent on each batch.

2—Hire additional personnel.

When surgical soap is made the time consumed is not much but the bottling of this solution takes hours. When hand lotion is made the problem is the same and so on through cough syrups, elixirs and the simple solutions. This at once brings to mind a bottler.

There are bottlers of every type, kind, and description from the small vacuum bottler doing one bottle at a time to the large rotary multiple headed models. The prices vary from $50.00 to many thousands of dollars. To pour by hand one gross of two ounce cosanyl requires one hour's time. The bottler of our choice can fill that same gross of 2 ounce cosanyl in only five minutes. This is a labor savings of 55 minutes or $1.82 on every gross of 2 ounce bottles. A year's total of 200 gross of 2 ounce bottles means a labor cost savings of $364.00 or 183 man hours.

These man hours will certainly provide time for manufacturing additional items. This savings is only on the two ounce size and does not consider the 8 ounce, quart and gallon sizes. Our choice of bottlers was a U. S. Bottlers Machinery Company Model B-2 which cost about $800.00 complete with cups, stems, centering necks, for four sizes



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of bottles, and each size bottle has a stem for each of three different types of liquids.

Another method to save time, and still present a more useful and convenient form of the preparations, is the use of collapsible ointment tubes. To fill one two ounce ointment jar requires one minute's labor. To fill one tube requires only three seconds. On a yearly use of 100 gross of tubes the labor saved will amount to $456.00. This saving in labor time will permit the purchase of an ointment tube filler and provide time for the manufacture of additional products. In addition to the labor savings effected by using the tubes, the tubes themselves cost 1¼ cents a piece less than the ointment jars. This is then an additional savings of $180.00 on a year's supply of tubes.

Good formulas . . To carry out any manufacturing program good formulas are a definite prerequisite. There are several places that formulas can be found, among the best of which is the *Bulletin of the American Society of Hospital Pharmacists.* This *Bulletin* has up to date formulas of many kinds. Another good source is the Institute on Hospital Pharmacy held each year. A manual we compiled contains almost all of the formulas presented at the past four institutes. These formulas have been developed by men who have the time, staff, and equipment for this practical experimentation. These are useful formulas, many or all of which are in use in hospitals throughout the country.

Those of you readers who represent the small hospital are most probably saying to yourselves that such large quantities are not feasible for your institution. Correct. Do not forget that any of these formulas can be reduced in size. The equipment you will require will be much smaller and at a resultantly lower cost.

When you have decided to undertake a manufacturing program, be sure to start off small. This means small batches of a few items. See for yourself just how much money can be saved and exactly what is the best procedure for the equipment you have. Start with the simplest items that do not require much equipment. Be sure to include all of your ingredient costs, labor costs, bottling and bottle costs, as well as the label costs.

All these factors must be considered before an accurate manufacturing cost can be determined. When you have an idea of how much time is involved in any certain procedure outline your manufacturing program and expenses as follows:

Column 1—item to be manufactured; take for example milk of magnesia.

Column 2—total used per year; using our figures we have 1,000 gallons.

Column 3—cost to buy this quantity $1,000.00

Column 4—cost to manufacture a like quantity $250.00

Column 5—savings effected per year $750.00

Column 6—equipment required, mixing tank with high speed agitator.

Column 7—cost of this equipment $185.00

Tabulate each and every item you think can be manufactured. Subtract the totals of column 7 from column 5. This should show you the savings effected each year as tabulated against the total equipment investment.

More costs . . When contemplating a manufacturing room do not forget to enter the cost of installing the machinery as well as the cabinets, plumbing, painting, electrical work, counter tops, etc. These expenses must be charged against the manufacturing program. In our own particular case the remodeling of the room cost almost twice as much as the cost of the equipment purchased.

What type of equipment to purchase is always the question. This can best be answered only after you have decided just what size is required. A small mixing tank of 20-30 gallons is best driven by a propeller type agitator mounted on one side of the top. A larger tank of 200-300 gallon capacity may use an hydraulically driven turbine with baffle plates. Remember also that stainless steel is wonderful for working pharmaceuticals. There are very few chemicals that we use that are incompatible with stainless steel. Ointment mills vary from a two pound size up to the ones having several hundred pound capacity. Your own particular needs will determine the appropriate size.

The last few pages of a formula manual which we have compiled contain lists of manufacturers who can make, or have available, equipment for pharmaceutical uses. Talk with these companies. They can often give excellent advice on their equipment as well as that made by their competitors. The hardest item we had to purchase was the steam jacketed kettle with agitator. Twenty-two bids were sent out with only 11 companies answering. Only three of these eleven quoted any price at all. Shop around. These companies often will not know exactly what you want unless your specifications are very detailed.

One company filed a no-bid when requested to quote on an item. A few weeks later one of their salesmen called. Much to my surprise he was able to quote on exactly what we wanted in spite of the fact that someone in the office had not taken time to check. Keep looking for the equipment. Restaurant suppliers have many items that can be used to good advantage. Filling station equipment suppliers have many tanks and pumps that can be used for storage or pumping pharmaceuticals. Buy what is wanted, and then only the best available. Do not forget stainless steel. Stainless usually costs more but there are hardly any replacements due to corrosion or wear.

More costs . . Let us glance quickly at a few manufacturing costs at Indiana University Medical Center:

Aluminum hydroxide gel ..... $1.00 per gallon

Aluminum ointment 20% ..... $2.50 per pound

(We were unable to locate any source for this ointment)

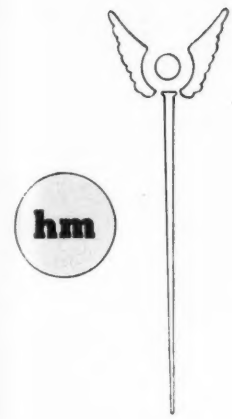
Milk of magnesia $.25 per gallon

Zephiran tincture $.97 per gallon

Emulsion sulfadiazine ..... $8.00 per gallon

Burow's solution .... $.65 per gallon

continued on page 120



accounting and recordkeeping

Administrative technique in the control of cost

part two

by **Harry E. Panhorst** • Associate Director • Department of Hospital Administration • Barnes Hospital • St. Louis

This is part two of an article which began on page 130 of the January 1952 issue. Mr. Panhorst is discussing some of the ailments of hospital personnel today.

Intelligent management . . overall management, not merely the appropriate handling of absentees . . can minimize the effect of outside factors such as housing and transportation difficulties. Irritating uncertainty, irregularity, and confusion in the factory are likely to be important causes of absenteeism. A worker spends a large share of his waking hours on the job. A man's essential requirements for a satisfactory existence do not alter when he walks through the hospital door as an employe. One of these basic needs is a continuity, a predictability, a routine of relationships in his life. Management must help to provide this or must risk the consequences.

The investigation found that at a time when absentees were being castigated as unpatriotic, management itself had its share of the blame to face and when government, industry and society were considering penalties without discrimination between groups and individuals there was serious risk of alienating the large group of conscientious workers. So maybe we, as hospital administrators, when we throw up our hands at the absenteeism problem, are failing to realize that at least indirectly it might be revealing our own administrative shortcomings.

If I ask you, as administrators, how many of you could tell me your absentee rate for last month? Yet, the acquisition of this information is very simple and again it certainly is an administrative technique or a diagnostic aid in helping us control the cost of our hospital care. If it is higher than 6% you have a clue to an administrative ill that is keeping up your cost because we know absenteeism is a symptom of a worker's attitude and his attitude is conditioned in a very large measure by the leadership from the top.

Testing . . Take the matter of testing employes upon hiring. The Schenley Company once estimated it cost them $4,000 to train a salesman before he could earn a dime for them.[4] Certainly it doesn't take that much to train an orderly, a presser in the laundry or a janitor but it does cost something, and if we can control that cost, our finished product (a well patient) will be more efficiently handled. True, employe testing in the hospital field and some of its specialties isn't easy to do because of the nature of the employment but a psychological interview keeping care of the patient uppermost in mind plus a general aptitude test and perhaps an interest test will at least steer the applicant into the proper channel.

Hospitals in the United States are more and more having to deal with labor unions. Elmo Roper, conductor of *Fortune's* poll, has stated that labor's real wants are:

1. Full employment at reasonably high wages.
2. A chance to advance.
3. Just to be treated like people.
4. A feeling of dignity and responsibility.

He also stated that other wants . . seniority, compulsory union membership, etc. . . are devices for satisfying the real wants.[5] Yet I wonder if these aims aren't very much what we ourselves want. So why not beat labor to the punch and in-

[4]Wm. E. Claypool, Asst. Administrator of University Hospital, Columbus, Ohio, in a presentation to Institute on Housekeeping and Laundry, Ohio Hospital Association, February, 1950.

[5]Lytle, **Job Evaluation Methods,** page 14.

stitute such policies in our organization because what management wants . . a good hour's work for an hour's pay . . is based upon management's greatest need . . full cooperation. And this cooperation is forthcoming when sound long-term policies are in operation.

One last word on employe relationships before we move on. In our institution we try to maintain an "open door policy." Any employe, after checking with his department head, can walk into any administrative office and tell the person behind the desk what he thinks. Time-consuming? Perhaps. It may be even meddling in the department head's business. But if that employe is angry it is a sign that he is fully awake mentally and, if he is mentally awake, he is thinking and, if he is thinking, you are being given free of charge some diagnostic findings that many hospitals pay a consultant to produce. Even if only 10% of what the employe states is true, look at the return you are receiving on your investment.

Cash intake . . Let us turn our attention for a minute to some more tangible methods of controlling our cost. One method might be to increase the cash intake and maintain the same relative expense item. Have you dug into your patient's day stay figures lately? What about the bed tied up by a chronically ill patient if you administer a hospital for acute illnesses? True, we are an aging population, and this particular type of hospital care is not available nearly to the extent it should be.

In a talk before the Association of Western Hospitals, one doctor[6] stated that the best care of the chronically ill will be provided most efficiently and economically when our hospitals assume the responsibility of providing facilities for our aged, incompetent and chronically ill. But he went on to say that "this type of care can be most effectively carried on either in a separate ward or a separate building associated with the general hospital."

Do you have in your institution, keeping your costs high and your revenue at a minimum, beds occupied with chronically ill? If you have a general institution for acute illness, you naturally have the best type of care possible . . and this care costs you money. The effective use of these services are not called for by the chronically ill since they are mostly a nursing problem.

Inasmuch as income from x-ray, laboratory and other procedures diminishes rapidly after the patients' first week of hospitalization, the financial seriousness of maintaining a large hospital population of patients with chronic illnesses is readily apparent. Compare what one 36-days' stay does to the income item as contrasted to four 9-days' stay patients using the same bed.

Have you recently taken a look at your proportion of private, semi-private and ward beds? Does the approximate number of each represent the demand of the community? It seems clear that within a very short period (5 to 10 years) most of the people in the United States will be covered by some type of medical insurance paying for inpatient and outpatient care. Is your institution readying itself for this change? Do you still have a number of the large $18 rooms that would be bringing you more income and easing the bed shortage if they were converted into two-bed rooms?

Commercial insurances are entering into the field of hospital coverage more every day and they certainly should pay for the services rendered their clients. Harper Hospital in Detroit has done away with "ward care" entirely. Since 70 per cent of the population is covered by Blue Cross and commercial hospital insurance this hospital says there is no demand for "ward care." Single and multiple bed accommodations priced at variable amounts, the lowest rate covering cost, now replace the former wards.[7]

Buying . . Since supplies are the second largest consumer of our expense dollar, let us look for a moment at some ideas about administrative control over the prices of supplies. We all pay considerable attention, we feel, to results obtained per labor dollar but how much scrutiny do we give to the purchasing angle?

This business of establishing control over prices so cost can be controlled is not easily done but maybe we can stimulate some thinking on it so our buying is more efficient.

Factors of failure . . In purchasing, two factors can wreck well-laid plans. One is the pressure of constant internal hospital emergencies and the other is the difficulty in procurement. Actually the cost of the article to our hospital may be secondary to the more important problem of keeping our unit functioning. Consequently the benefit to be obtained from establishing controls over prices paid should be carefully weighed against the cost of maintaining such administrative control when speed and priority ratings are of the essence.

The purchasing office, storeroom, and central supply have to be closely integrated if the most efficient use is to be obtained of the purchasing dollar. If good liaison does exist it is possible to realize the benefits of volume purchasing, maximum control over obsolescence, a balanced inventory and elimination of shortages.

Of course, there have always been gifts, kickbacks and maybe some rather persuasive (or perhaps insistent) entertainment connected with the purchasing office. Handling this situation is not easy because of the possible involvements but it should be discouraged vigorously at all times.

Another item to watch is when the supplier had rendered satisfactory service over a period of time which action sometimes induces the buyer to take a line of least resistance and become tied to a single source of supply for particular items. These sources of supply may not be the most advantageous from a price standpoint but, in the face of freedom from quality and delivery troubles, price considerations too often are relegated to second place.

There is one positive way of assuring advantageous prices and of establishing a basis of control over prices and that is to shop around. But one wonders just how much the personality of a certain salesman mitigates this principle, aided and

[6]Dr. J. A. Kahl, Seattle, Washington, Acting State Director of Health

[7]**Trustee,** June 1951 — page 6.

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abetted by emergencies which allow no time to shop around.

Nevertheless the principle of shopping around is still a sound one. There are some procedures which might pay dividends for you, as formal competitive biddings on major purchases, continuous special studies of the cost of certain articles on a monthly basis and telephone price shopping on certain items. Mix them up in any proportion you like and these "personality salesmen" might discover you or your purchasing department aren't such a sure bet. (A word of caution however . . constant scrutiny of purchasing prices is greatly to be desired but price is not the only consideration in selecting a source of supply. Quality and delivery dates are also important.)

Review of purchase orders can range from a cursory check by someone familiar with prices and market conditions to a formal audit by an internal auditor. Maybe that friendly relationship between you and your No. 1 man (controller, ass't administrator in charge of purchasing, or whoever it might be) might be strained a little but the chances are he will strive harder if he knows that an inspection might be forthcoming at any time. The result you want is the greatest element of control possible over your cost even if it does reach into the inner sanctum.

It is again to be emphasized that it is not possible to arrive at any magic formula whereby internal control can be established over purchasing prices and consequently the control of your costs. In this present period of shortages and difficulties in procurement, however, the consideration of price has a tendency to be relegated to the background and the need for control over purchase prices becomes even more apparent. Individual problems in each case must be considered.[8]

Another money-saving device is the financial ability to discount bills. Do you have enough cash to pay your billings promptly so that the discount can be taken advantage of or do you end up paying the full amount?

Judgment . . I have attempted to enumerate and discuss briefly some of the many problems and techniques in cost control. I have merely touched on the single, most important factor in this matter . . the person who employs the techniques, evaluates the results and takes action based on those findings. It is true that research can discover facts but research can't make administrative decisions. The matter of cost control rests ultimately with the administrator and the intangible qualities of judgment and leadership which he possesses. These qualities are intangible and are the hardest to control because they are so interwoven within the personality of the man himself. I would like to illustrate this intangible matter of judgment and leadership by the following story:

[8]Arthur Andersen and Co., **Internal Control Over Purchase Prices.**

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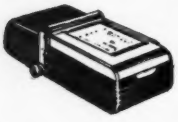

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During World War II a Navy seaplane was carrying an impressive cargo of top brass . . both Army and Navy officers. During the flight, and close to its termination, one of the generals went forward to the Navy pilot and asked if he might fly the ship part of the way.

"Certainly, sir," the young pilot agreed. "In the air she handles just like any other plane."

The general took over the controls from the co-pilot and did a very fine job of piloting the ship. Very shortly thereafter they arrived over their destination, a combination air-strip for land-based planes and a seaplane base. Automatically the general circled the air-strip and nosed the big ship down for a landing. The Navy pilot coughed discreetly, leaned over toward the general, and in as low a voice as he could use and still be heard, he said, "If I might make a suggestion, sir, I think this boat would be more comfortable if we land her on the water."

The general quickly leveled off and returned control of the flying boat to the Navy pilot. After a smooth landing and the seaplane had been taxied to her mooring, the general spoke to the pilot. "Thank you for your tact in preventing me from making a silly and dangerous blunder," he said.

Then, completely surprising the pilot out of any chance to reply, the general opened the hatch, *and stepped out into thirty feet of water!*[9]

While we as administrators probably do not have our mistakes brought home to us so effectively, we do make errors in our techniques used to control cost, but the solution of the problem is not in the technique . . it is in the ability to conceive, organize and execute using the technique as a tool. ■

[9]Lester Miles, **Brass Hat or Executive,** Chp. 1.

■ MORE MISTAKES ARE MADE . . many more . . by not looking than by not knowing.

—Sir William Jenner

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food and dietetics

Under the editorial direction of J. Marie Melgaard, hospital dietitian

Michigan hospital cuts cost of feeding staff, personnel

■ A PROGRAM aimed at cutting the cost of feeding its personnel produced surprising results for the St. Lawrence Hospital, Lansing, Mich. Before the program was undertaken in 1949 it was costing the hospital about 55 cents per person to feed doctors, nurses and employes. The figure at the present time is 31.5 cents, according to the head dietitian, Sister Mary Rita. The hospital was founded in 1924 and now has beds for 225 patients plus facilities for 60 infants. Sister Mary Josephine is head.

The program of cost cutting was undertaken in 1949 at a time when inflation was making it increasingly difficult to keep costs in line. It is relatively simple to control the costs of meals served on trays, according to Sister Mary Rita, but very difficult to do much when meals are part of the employe's remuneration and are not limited in any way. The program, however, never had the object of shifting the burden to the employe. Rather, its purpose was to reduce costs by controlling waste in both food and labor.

Raise pay . . Since it is impossible to exert any kind of control when employes are given their meals, the first phase of the program involved raising the pay to an average of what had been paid in food. From the day the workers started receiving the higher pay they started paying for each item of food they received. To make the shift easier there was a trial two-week period during which the workers had a chance to see how much their meals would cost without actually paying for them.

"So-called free meals are not really fair to all," explains Sister Mary Rita. "The individual who eats heavily gets more than the light eater. Under our program the average person comes out just about the same as his extra pay covers the cost of his meals. We have no wish to profit on the meals served to employes and do not do so. Actually the prices of the various items are based on a markup of ten per cent over food cost, which is actually less than cost. If an employe wishes to eat outside he may."

The next step in the program was concerned with consolidating the five existing dining rooms into one. The idea behind the five dining rooms was to have a separate room for each classification of hospital personnel. There was one for men, one for women, one for student nurses, one for graduate nurses and one for professional people.

Three of these dining rooms had been all in a row, and these were converted into one large dining room by tearing down the dividing walls, making a room that could seat 96 at a time. The other dining room

Serving line . . in new cafeteria at St. Lawrence Hospital, Lansing, Mich.

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was retained for the special use of the staff doctors and the other has been converted into storage space.

Cafeteria . . Once the five dining rooms had been consolidated into one large one there was the further problem of reducing labor costs, and this was done by setting the room up as a cafeteria. It is very difficult to evaluate the saving here because of the greatly increased volume done by the new facility, but it is estimated that the cafeteria produced a labor saving of about 25 per cent.

The cashier, required by the new system, was a new cost, but otherwise more food was served by fewer people. Regular cafeteria help is now one cashier, one bus girl, two counter girls at night and morning and three counter girls at noon. With these the cafeteria serves 110 at breakfast, 200 to 280 at noon and 175 at supper.

The service line was installed at a cost of about $4,500 and consists of a five-foot refrigerated salad counter, a four-foot steam table, a coffee maker and a toaster.

At the time the cafeteria was installed the hospital set up a special dishwashing room to go with it. Previously the dishes from the five dining rooms had been washed in the main dish washing machine, but this had meant running it hour after hour until all the dishes were through. It also meant hauling the dishes from each of the rooms.

The dishwashing room for the cafeteria is set up directly across the hall from the cafeteria, and the dishes are carried across on trays and pushed through a receiving window. The dishes are washed just about as fast as they are received and when the cafeteria completes serving a meal and closes, the dishwashing room closes shortly afterwards.

The dishwashing room was installed at a cost of about $3,000, according to Sister Mary Rita, and includes a dishwasher and a prewasher. Stainless steel counters connect the receiving window, the pre-washer, the washer and continue on along the wall.

Costs cut . . The results of this entire program have been highly gratifying to the hospital management. The cost of meals to the average employe had remained the same, while the cost to the hospital had dropped from around 55 cents in May 1949 to 31.5 cents in May 1951. It must be made clear that the idea behind charging the worker for his meals was not to shift the cost to him and it did not work out this way in practice. Charging regular prices merely enables the hospital to control its food costs.

Sister Mary Rita . . head dietitian, St. Lawrence Hospital, Lansing, Mich., examining new equipment

One reason the hospital was able to reduce the cost of the meals served the workers is found in the reduction of waste made possible under the new system. When an employe felt the food was free he had a natural tendency to throw it around and load his plate with more than he could eat. The same employe does not do this when he pays for each serving of each item.

In addition there is a saving by serving in one big room instead of five small ones. The kitchen staff might plan on serving 50 in one dining room only to have just 30 turn up, while another room might be overcrowded. Making sure that five rooms had enough meant that five rooms had too much. When just

Sample menu . . in employe's cafeteria, St. Lawrence Hospital, Lansing, Michigan

one room has too much, the waste is not so great.

There was another direct waste in the old system. The food had been kept heated in hot food carts for the dining rooms and any that remained very long in these carts would be spoiled and often actually burned. The steam tables in the cafeteria, on the other hand, keep the food warm without damaging it, says Sister Mary Rita.

How do YOUR dietary costs compare with those on page ten ?

Visitors . . Another advantage of the cafeteria, according to Sister Mary Rita, is that it makes it easy to feed visitors who want to eat on the premises. Previously this was often something of a problem but now the cafeteria is open to the public and anyone is free to eat there. This also helped a little on the food cost question because the outsider pays 50 per cent higher than the listed prices. The hospital now feeds about 100 outsiders every day.

When the change from private dining rooms to cafeteria had been contemplated there had been fears that breaking down the classifications might cause trouble. However, this has not been the case and the doctors seem to regard it as perfectly natural to stand in line behind a trainee or a pot scrubber.

If anything, the new cafeteria has given the personnel of the hospital a big lift because of its fine appearance. The new service counter is a thing of beauty and the large, newly decorated dining hall is a lot more pleasant than the small private dining rooms. ■

■ **WINTRY BLASTS WERE DISPELLED** in some medieval hospitals by wheeling movable stoves to the bedsides of the sick.

■ **HE THAT WOULD LIVE** in peace and at ease must not speak all he knows, nor judge all he sees.

—Benjamin Franklin

■ **WE ARE ALWAYS** complaining that our days are few, and acting as though there would be no end to them.

—The (Illinois) Welfare Bulletin

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GRAVY GIVES HOSPITAL MEALS A TOUCH OF HOME!

Patients perk up when they see—and *taste*—rich brown gravy made with Kitchen Bouquet. This unique blend of 14 garden-fresh vegetables, herbs and spices adds no artificial flavor. Used by good cooks and chefs for 75 years to bring out *true* meat taste and give gravy an appetizing, deep brown color.

Here's another tip: you'll save meat-shrinkage—get extra servings—by slow-roasting at 300°F. For rich brown crust, brush the meat, before roasting, with Kitchen Bouquet.

Always use Kitchen Bouquet to get the most flavorful meat gravy at only a fraction of a penny per serving.

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**Test data available upon professional request.*

JUST MY MISCELLANY

MARIE MELGAARD

■ HERE are ten ways to increase efficiency in the storage, care and issue of food supplies:

1. The storeroom for canned goods and staple supplies should be well ventilated and properly lighted. No steam or hot water pipes should run through a storeroom. Red quarry tile is best for a floor, and the floor should have a drain. The office of the storekeeper should be so arranged that he can see all parts of the storeroom, delivery entrance, and issue window or counter.

Metal adjustable and substantial shelves are the best for storage with lower shelves at least eight inches off the floor, and shelves should not be up against any walls. Aisles between shelves should be wide enough for trucks and easy passage. No goods should be stored on the floor; use 12-inch platforms or dunnages. Storeroom space should not be sacrificed for overstocking on items bought on quantity price purchasing.

The storage area must be kept clean, *dry*, free from odors, vermin and rodents. Cleanliness is the best prevention. All spilled foods should be cleaned or brushed up immediately and the storeroom should be inspected by an exterminator at least once a week. Storeroom should have its own utility closet near at hand for cleaning supplies, mop, broom, brushes, etc., and the storekeeper should have time enough to clean and put the storeroom in order at the end of each day. The walls and floor should be scrubbed down, not *hosed* down.

2. Goods should be arranged on shelves according to classification: cereals, spices, juices, jellies, flavored gelatines, extracts, leavening agents, powdered beverages and the like. Heaviest products should be on the lower shelves. Lighter and less frequently issued goods can be stored near the top. If possible, a specific number of units can be stored to each shelf as this will save time in making physical inventories.

Sugar, flour, rice, and bulk goods, if issued in small quantities, should be stored in metal bins on casters. All metal containers should have tight fitting lids or covers and be neatly labeled so that no time is lost in finding supplies. Packaged goods, such as cereals, cornstarch, powdered sugar, etc., take less time in handling and are more sanitary.

Barrels should be high enough so that containers can be put under the faucets for filling. No. 10 canned goods should be stored in cases and arranged in alleys or rows with aisles between, easily accessible, and the storage space should be moderately cool . . about 50 degrees F.

3. Oldest merchandise should be placed in front on shelves and used first before new packs are issued. Foods used most frequently should be nearest to the receiving entrance and issue window.

4. The storekeeper should have a definite schedule and certain hours for issuing supplies. Food supplies should not be issued without properly approved requisitions. No issues should be made on verbal orders or promises of requisitions later. Stores requisitions should be filled by actual count, measure, weight and specifications. All issues should be as thoroughly checked as deliveries.

5. Food supplies should be checked in carefully to be sure that quality, weight, count and pack meet the purchase specifications. Dealers should have a definite time for deliveries as much as possible. If an error has been made, it must be rectified before goods are accepted. One person should be authorized to accept and sign for all goods received. Records should be kept of goods received, and returned for credit, breakage, spoilage, swells, leaks or over-purchasing.

6. Accurate scales are essential for all deliveries and issues. It is necessary to have both a platform scale for bulk goods and a hanging scale for small items. Products weighed out for issue should be close to a table, scale and point of issue.

7. Large issues from storerooms encourage waste and spoilage. In the average institution it is best to issue goods from the storeroom once a day or possibly three times a week.

8. The last drop should be obtained from cans of oil, kegs of vinegar, bags of flour, sugar, etc.

9. Return and get credit for all empty cases, bottles, egg crates, fruit baskets or hampers, potato bags, etc. (I once turned in about $1,400 to the hospital treasury over a period of a year and a half in this way.)

10. Storerooms and storage cabinets should be kept locked at all times, with only one or two persons responsible for the keys. No one should have access to the storage area unless he has business there. Food supplies on shelves are the same as money in the bank. ■

Mt. Sinai, N.Y., has centennial

■ CELEBRATION of the centennial of Mt. Sinai Hospital of New York began on Jan. 17 and will continue through 1952. The opening day's ceremonies were presided over by Alfred L. Rose, president of the hospital, who reviewed the changes in the hospital's role during the century since its establishment as a 45-bed institution in 1852.

In its first year Mt. Sinai treated 225 patients at a cost of $5,482 as compared with 40,000 a year at present with an operating cost of $5,500,000. The first Jewish hospital in the United States, its fame spread rapidly so that ten years after its establishment, in 1862, its staff and capacity were expanded so as to provide facilities for the care of soldiers wounded in the Civil War.

Four student nurses from the hospital's training school added color to the opening of the centennial celebration by changing their modern uniforms for dresses of 100 years ago; and conspicuous was a three-tiered birthday cake topped with a sugar model of the hospital's first home, a four-story building at 138 West 28th street. ■

It Pays to own a STEAM-CHEF

When you invest in a piece of major equipment like a steam cooker, why take less than the finest? A careful analysis will convince you that, from *every* angle, Steam-Chef is your *best* buy. Just as it outsells other steamers, it out-performs other steamers.

If your needs are for *less* than a heavy-duty steamer, consider Steamcraft, our Junior model. It offers you *all* the basic advantages of steam cooking, at lower cost and with somewhat smaller capacity, than the larger Steam-Chef.

With either one of these steamers, you step up kitchen efficiency, deliver more cooked food at less cost and with less help. With your cooker ready for action you can usually cook more *quickly* than by any other method. You save *waste* from over-cooking and preparing *too much* at one time. Your steamer is highly responsive to the day's actual requirements. Our free booklet "For Better Steaming", tells you how to steam a great variety of foods. We'll recommend the right size and model for your needs. Write for complete information.

Steam-Chef standard size steamers are made in several sizes. Steamcraft Junior models are made in 1 or 2 compartment sizes, for counter or table use or mounted on their own bases. Any of these steamers is furnished for direct steam line, or for any kind of gas.

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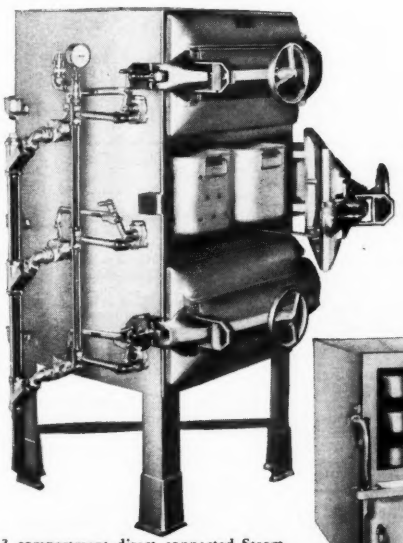
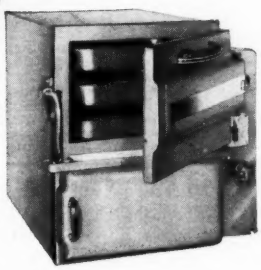


(Below) one compartment CUB Steamcraft counter model. Also made in two compartment size. For direct steam, or for gas operation. With or without base. Indicating timer or fully automatic controls optional.



3 compartment direct connected Steam-Chef. Also made in 2 or 4 compartments. Gas or electrically operated models, too.

What's your score on this Monosodium Glutamate Quiz?

1 TRADE MARK OF THE LARGEST PRODUCER OF PURE MONOSODIUM GLUTAMATE IS AC'CENT.

Yes. Ac'cent is pure (99+%) monosodium glutamate in crystalline form produced solely from cereal or vegetable sources. Ac'cent is a basic seasoning—it brings out natural flavors of many foods.

2 DOES AC'CENT ADD FLAVOR TO FOOD?

No. Ac'cent adds no flavor, color or aroma of its own to foods. Its sole function is to *make good food taste better* by intensifying weak or depleted flavors, also by reviving natural flavor which may be lost through storage, cooking, or delayed serving.

3 AC'CENT IS AS EASY TO USE AS SALT.

Yes. Ac'cent, known as the "Third Shaker," is used with salt, and in most dishes to which salt is added . . . meats, poultry, fish, vegetables, gravies, creamed and casserole dishes, stews, etc.

4 AC'CENT IS AN ECONOMICAL PRODUCT.

Right you are! For a fraction of a cent per serving, Ac'cent makes low-cost dishes more appetizing, hence more appealing and popular.

5 AC'CENT IS PRACTICAL TO USE IN ALL FOOD OPERATIONS.

Yes. Wherever good food is served—restaurants, hotels, hospitals, schools, industrial plants—Ac'cent can be added to any large-quantity food formula with little or no change in basic proportions.

6 AC'CENT WILL HELP SOLVE MANY FOOD SERVICE PROBLEMS.

True. Ac'cent builds up the taste of bland foods, brings out natural food flavors, compliments other seasonings, combats steam table fatigue, retains natural flavors longer, solves the "leftover" problem by reactivating depleted flavors.

Is more information about Ac'cent available?

You bet. Just write **AMINO PRODUCTS DIVISION**

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PURE MONOSODIUM GLUTAMATE

...makes good food taste better!

monthly menus (hm) . . . March

Suitable for staff, personnel and patients not requiring special diets

		Breakfast	Dinner	Supper
Sat.	1.	Baked Rhubarb; Hot Cereal; Griddle Cakes; Syrup	Braised Short Ribs of Beef; Brabant Potatoes; Harvard Beets; Tossed Green Salad; Steamed Chocolate Pudding	Vegetable Soup; Corned Beef Hash; Hot Slaw; Piquant Egg Salad; Pineapple Cream
Sun.	2.	Grapefruit Segments; Hot Cereal; Pork Sausage; Kolaci	Broiled Sirloin Steak-Mushrooms; Shoestring Potatoes; Pimiento Cauliflower; Golden Glow Salad; Graham Cracker Roll	Tomato Bisque; Jellied Veal Loaf; Bu. Mixed Beans; Health Salad; Ice Cream Cup Cake
Mon.	3.	Tomato Juice; Hot Cereal; Scrambled Eggs; Toast	Yankee Pot Roast; Watercress Potatoes; Whole Kernel Corn; Cabbage-Nut Slaw; Peach Betty	Okra Soup; Panned Liver with Bacon; Delmonico Potatoes; Marinated Cucumbers; Date Bars
Tues.	4.	Bananas-Cream; Cold Cereal; Omelet; Toast	Stuffed Meat Loaf; Hash Brown Potatoes; Minted Carrots; Lettuce-1000 Is.Dr.; Caramel Apples	Creole Soup; Vermont Chicken Pie; Bu. Lima Beans; Grapefruit-Endive Salad; French Fruit Pudding
Wed.	5.	Stewed Prunes; Hot Cereal; French Toast-Jelly	Roast Leg of Lamb; Whipped Potatoes; Peas in Cream; Stuffed Celery with Relish; Cherry Roly Poly	Consomme; Braised Beef Cubes with Noodles; Julienne Vegetable Salad; Raspberry Ripple Ice Cream
Thurs.	6.	Pineapple Juice; Hot Cereal; 3-Minute Egg; Toast	Veal Cutlet; Stuffed Baked Potato; Broiled Tomato Half; Peach Bloom Salad; Honeycomb Pudding	Mushroom Bisque; Frizzled Beef with Hot Biscuits; Fritoes; Shredded Lettuce; Vienna Tart
Fri.	7.	Kadota Figs; Hot Cereal; Poached Egg; Toast	Broiled Whitefish-Lemon Butter; Parslied Bu. Potatoes; Fresh Spinach Mounds; Assorted Relishes; Iced Molasses Cookies	Fish Chowder; Crisp Bacon; Asparagus on Toast-Cheese Sauce; Tomato-Cress Salad; Orange Sherbet
Sat.	8.	Sliced Oranges; Cold Cereal; Shirred Egg; Raisin Toast	Smothered Steak; Paprika Potato Balls; Bu. Broccoli; Mexican Salad; IceBox Pudding	Vegetable Soup; Barbecued Pork; Fried Okra; Cornbread; Tossed Salad Greens; Peach Pie
Sun.	9.	Blended Fruit Juice; Hot Cereal; Scrapple; Danish Coffee Twist	Apricot Glazed Ham Steak; Fluffy Rice; Bu. Peas & Carrots; Chiffonade Salad; Praline Ice Cream	French Onion Soup; Chicken Salad; Baked Potato; Olives-Celery Curls; Bing Cherries; Frosted Graham Crackers
Mon.	10.	Grapefruit Half; Hot Cereal; Baked Egg; Toast	Fillet of Beef with Vegetables; Golden Brown Potatoes; Wilted Spinach Salad; Rebecca Pudding	Lentil Soup; Bacon-Cheese Sandwich; Fr.Fr. Egg Plant; Fruit Salad; Lazy Daisy Cake
Tues.	11.	Prunicot; Hot Cereal; Sausage Links; Sweet Rolls	Mock Chicken Legs; Roasted Potatoes; Bu. Zucchini; Pickle Relish Salad; Fruit au Gratin	Corn Chowder; Stuffed Green Pepper; Beet-Egg Salad; Mocha Sponge Cake a la Mode
Wed.	12.	Orange Juice; Hot Cereal; Fruit Omelet; Toast	Stuffed Shoulder of Veal; Potato Cakes; Glazed Carrots; Jellied Vegetable Salad; Cream Puff	Bouillon; Spaghetti Italienne with Tiny Meat Balls; Green Salad; Pineapple Tidbits; Ginger Snaps
Thurs.	13.	Bananas-Cream; Cold Cereal; Fried Cornmeal Mush-Syrup	Sizzling Steak-Mushrooms; Mashed Potatoes; Fr.Fr. Onion Rings; Spiced Watermelon Pickles; Lemon Tapioca	Alphabet Soup; Canadian Bacon; Vegetable Pinwheels; Tomato Salad; Devils Food Peach Shortcake
Fri.	14.	Apple Sauce; Hot Cereal; Shirred Egg; Cinnamon Toast	Tenderloin of Trout; Maitre d'Hotel Potatoes; Green Beans, Gascon; Normandy Salad; Jelly Roll	Mock Bisque; Finnan Haddie Rarebit; Potato Puff; Tossed Vegetable Salad; Hot Fruit Compote
Sat.	15.	Pineapple Wedges; Hot Cereal; 3-Minute Egg; Toast-Jelly	Lamb Pot Pie-Sweet Potato Topping; Lima Beans; Cucumber-Radish Salad; Fruit Dumpling-Foamy Sauce	Consomme Julienne; Cubed Steak Sandwich; Cottage Potatoes; Shredded Lettuce; Oatmeal Bars
Sun.	16.	Frozen Strawberries; Cold Cereal; Bacon Curls; Orange Bowknots	Roast Turkey-Giblet Gravy; Riced Potatoes; Asparagus Tips; Assorted Relishes; Peanut Brittle Ice Cream	Swiss Potato Soup; Cold Luncheon Meats-Gherkins; Corn a la Southern; Fruit Salad; Toasted Crackers-Cream Cheese-Jelly
Mon.	17.	Fruit Nectar; Hot Cereal; Scrambled Eggs; Toast	Boiled Dinner-Corned Beef-Potatoes-Cabbage-Carrots; Lime Krisp Salad; Shamrock Cookies	Fruit Cocktail; Roast Beef Hash; Potato Flakes; Spring Garden Salad; Pineapple Mint Ice Cream Sundae
Tues.	18.	Stewed Rhubarb; Hot Cereal; Poached Egg on Toast-Cream Sauce	Veal Curry with Rice; Paprika Cauliflower; Polka Dot Salad; Butterscotch Blanc Mange	Vegetable Soup; Barbecued Pork Sandwich; Shoestring Potatoes; Pickles; Delicia Cake
Wed.	19.	Stewed Apricots; Hot Cereal; Country Sausage; Muffins-Jam	Minted Fillet of Lamb; Franconia Potatoes; Bu. Peas; Cabbage-Carrot Salad; Peach Melba	Scotch Broth; Swedish Meat Balls; Chantilly Potatoes; Lettuce Wedge-Fr-Dr.; Fruited Eclair
Thurs.	20.	Grapefruit Half; Hot Cereal; 3-Minute Egg; Raisin Toast	Waikiki Pork Chop; Whipped Potatoes; Sliced Tomatoes; Krisped Relishes; Apple Cheddar Betty	Dixie Chowder; Chicken Tamale Pie; Bu. Crumb Noodles; Banana-Nut Salad; Fruit Jumbles
Fri.	21.	Kadota Figs; Hot Cereal; Pancakes-Syrup	Deviled Scallops; Lyonnaise Potatoes; Spinach a la Swiss; Cole Slaw; Lemon Cheese Cake	Tomato Soup; Salmon Loaf with Creamed Peas; Baked Potato; Macedoine Salad; Ambrosia
Sat.	22.	Apple Juice; Hot Cereal; Crisp Bacon; Pecan Coffee Cake	Stuffed Flank Steak; O'Brien Potatoes; Bu-Wax Beans; Grapefruit-Cherry Salad; Spanish Cream	Hamburger-Bun; Potato Salad; Pickles-Green Onions; Pineapple Tart; Hot Cocoa
Sun.	23.	Bananas-Cream; Cold Cereal; Scrambled Eggs; Popovers-Preserves	Sirloin Tips-Bordelaise Sauce; Parslied New Potatoes; Brussels Sprouts; Romaine-Cucumber Salad; Strawberry Ice Cream	Cream of Vegetable Soup; Bacon-Cheese Rolls; Chef's Salad; Fruited Gelatine; Macaroons
Mon.	24.	Blue Plums; Hot Cereal; Shirred Egg; Toast	Pot Roast of Beef; Browned Potatoes; Turnip Greens; Endive-Tomato Salad; Burnt Sugar Cake	Consomme; Grilled Bologna; Macaroni au Gratin; Celery Curls-Radishes; Chocolate Meringue Pudding
Tues.	25.	Sliced Oranges; Hot Cereal; Bacon Curls; Brioche-Jelly	Ragout of Veal; Potato Cakes; Succotash; Spinach-Beet Slaw; Coconut Banana Custard Tart	Noodle Soup; Baked Ham; Vegetable Casserole; Lettuce-Fr-Dr.; Baked Apple-Raisins
Wed.	26.	Stewed Peaches; Hot Cereal; Omelet; Toast	Beefsteak Pie; Cottage Potatoes; Creole Celery; Golden Glow Salad; Four Fruit Pudding	Beef Bouillon; Chicken Chow Mein with Chinese Noodles; Steamed Rice; Toasted French Bread; Shredded Lettuce; Pineapple Delicious
Thurs.	27.	Prune Juice; Cold Cereal; Griddle Cakes-Syrup	Broiled Lamb Chop; Whipped Potatoes; Asparagus-Vinaigrette Sauce; Watercress-Egg Salad; Refrigerator Cheese Cake	Oxtail Soup; Toasted Ham & Cheese Sandwich; Fr.Fr. Potatoes; Fruit Salad; Blueberry Cobbler
Fri.	28.	Grapefruit Half; Hot Cereal; 3-Minute Egg; Toast	Fish Fillet, Italienne; Bu. Crumb Potatoes; Pimiento Green Beans; Orange-Date Salad; Rice Custard	Potato Chowder; Hot Stuffed Deviled Eggs; Health Salad; Tea Biscuits-Jam; Frozen Strawberries-Sugar Wafers
Sat.	29.	Tomato Juice; Hot Cereal; Poached Egg; Toast	Meat Loaf-Celery & Mushroom Sauce; Lyonnaise Potatoes; Fresh Spinach; Sunshine Salad; Cherry Glace Pie	Cream of Asparagus Soup; Barbecued Spare Ribs; Mashed Potatoes; Hot Slaw; Lime Sherbet
Sun.	30.	Emperor Grapes; Hot Cereal; Scrapple; Cinnamon Roll	Oven Baked Chicken; Bu. Noodles; Frozen Broccoli; Avocado-Tomato Salad; Tri-Fruit Ice Cream	Mushroom Soup; Chili Hot Wieners; Potato Salad; Pickle Relishes; Angel Food Pastries
Mon.	31.	Blended Fruit Juice; Hot Cereal; 3-Minute Egg; Raisin Toast	Roast Virginia Ham-Orange Sauce; Riced Potatoes; Bu. Carrots; Banana-Nut Salad; Norwegian Prune Pudding	Vegetable Soup; Chicken Wings-Cream Gravy; Spanish Rice; Tossed Green Salad; Washington Pie

CITRUS JUICE ASSAY

Long welcomed in home and institutional kitchens for its convenience, economy and flavor—*frozen* citrus is now acknowledged the "nutritive equal" of fresh. The Council on Foods and Nutrition of the American Medical Association has declared* that—under modern processing methods—approximately 98 percent of the vitamin C content can be retained in the frozen concentrated juice. And, when properly stored (below its freezing point), there is practically no loss of vitamin C. Frozen citrus can thus be confidently recommended for diets at all ages, including infancy.

**J.A.M.A. 146:35, 1951.*

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

Louis H. Pink

continued from page 58

70 to 80 per cent of the hospital bills of their members."

Mr. McNary pointed out that in the same year the Michigan Blue Cross Plan covered over 90 per cent of the essential items on the average hospital bill.

A nice picture, Mr. McNary. Mighty nice. ■

"Hospital bills and inflation"

■ J. ALBERT DURGOM, executive director of the New Jersey Blue Cross Plan, in an address to the Citizen Health Council of New Jersey in November gave a penetrating presentation of the facts relating to the economics of the payment of hospital bills.

"Hospital bills always present a financial problem," said Mr. Durgom, "not only in times of economic depression but acutely during inflationary prosperity as actually demonstrated in our present economy."

After tracing the financial problem of hospital bills and the development of the voluntary health program, Mr. Durgom "projected the analyses of facts in terms of an approach to a solution in the public interest." He revealed that "the economic dislocation of the 30's set the stage for the creation of a voluntary hospital benefit program."

It was during this period, when a hospital bill or even part of it could not be paid readily by the average patient, yet services had to be rendered by the hospitals, that the prepayment voluntary hospitalization idea was born. Based upon the idea conceived by a single hospital in Dallas, Texas, and confined to the benefit of a group of school teachers, a group of hospitals and public spirited citizens in Newark, N. J., established the first voluntary health program in the country, now known as the Blue Cross.

Through the 30's the Plan grew; in the 40's it flourished; in the 50's the Plan was faced, as were others throughout the country, "with the challenge of conflicting economic forces at work. . . The conflicting economic forces . . . are the product of an inflationary spiral moving at the whirlwind speed of cyclonic economic turmoil," says Mr. Durgom.

He makes clear that employment and per capita income are at the highest peak in our nation's history; that the average wage earner is enjoying the highest standard of living in the history of our democracy . . the highest standards in the basic needs of food, shelter and clothing. He makes clear, on the other hand, that hospitals are faced with a shortage of needed personnel and the highest operating costs in the history of health care, and that the average wage earner does not save enough money to meet the contingencies of the ever-increasing high cost of health care. Inflation places a financial stress on the hospitals and a limitation on the ability of the people to pay increasingly higher hospital bills. These conflicting observations, Mr. Durgom states, present a challenge to the public, the hospitals, doctors and employers.

"The New Jersey Plan makes constant study of underwriting and administrative practices to keep the trend of experience in balance as far as it is mathematically possible," he reveals.

He further reveals that today four out of every five hospital bills are paid in full by the Plan's payment to hospitals; in the remaining fifth case the Plan makes a comparatively substantial payment as allowance toward a hospital bill not eligible for full Plan coverage.

Despite the increased cost of living, the Plan continued to make "service benefits" available to subscribers on the same principle as before inflation. "The one general increase in subscription rate announced in 1949 was substantially less than the already increased hospital bills . . thus assuring the subscribing public of the most effective method of combating the inflationary effect on the high cost of illness. This development was carried out without hedging on any benefits."

In November of 1950, the New Jersey Plan announced an increase of "the 21 full benefit days to 120 full benefit days and continuing partial benefit days to the extent of 245 such partial days to total 365 benefit days for a contract year for eligible conditions. This program of extended benefit days was made available without increase in subscription rate."

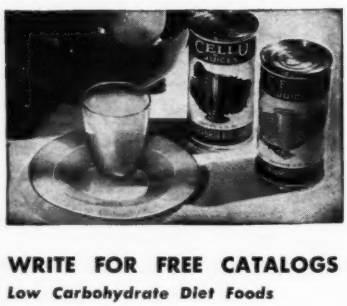
This is, indeed, as Mr. Durgom points out, a most generous contract. One full year of utilization under this program designed to help meet catastrophic illness requiring an abnormally long stay in the hospital has just been completed. Significant in the New Jersey long-stay plan is the fact that there is no elimination of any portion of the first part of the hospital bill; the New Jersey Plan pays from the first day of admission and has paid hospitals several thousands of dollars in some cases.

Today, the New Jersey Plan has a total enrollment of over 1,560,000 persons, 223 cooperating hospitals.

TASTY FRUIT JUICES —

FOR THE DIABETIC

Add taste-appeal to sugar-restricted diets with Cellu Canned Fruit Juice. Unsweetened, undiluted — just the whole juice of fresh, sun-ripened fruit. All popular fruit juices available. Food values printed on the label, for ease in diet calculation.



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Over 2,100 of the 6,000 enrolled firms are covered by employer contribution. The Plan has paid out over $80,000,000 toward hospital bills since its inception and is currently paying out over $1,425,000 a month to hospitals. This means that over 92 cents of the subscriber's dollar is being paid for actual hospital care; approximately 8¢ of each dollar is used for total administrative expense and for reserve.

"The continued successful performance of the New Jersey Blue Cross Plan depends upon the continued cooperation of subscribers, hospitals, doctors and industry," Mr. Durgom declares. "As a non-profit organization, the New Jersey Blue Cross Plan is dedicated to the job of making available maximum benefits at minimum cost for the greatest number of people.

"To underwrite a health program, the Plan cannot promulgate rates to provide for certain needed benefits without also taking into consideration the element of human behavior . . . a factor which poses a challenge for needed cooperation to combat the ravaging effect of inflation of the hospital bills.

"Cooperation of employers in contributing toward enrollment cost, together with cooperation of hospitals, doctors and patients, would mean more effective control of the present day high cost of hospitalization. With that control, the New Jersey Blue Cross Plan could look forward with hospitals to the ultimate goal of making available full coverage for every type of hospital service needed for the treatment of every patient hospitalized.

"If the patients, hospitals, doctors and employers meet this challenge in the face of our present day economy, there will be preserved the greatest single voluntary movement ever conceived in the annals of American enterprise through individual initiative. If such results of voluntary cooperation cannot be achieved, the problem of further increasing charges in hospital bills may become academic to the voluntary movement, because the alternative will be government control of the entire health field."

Thus ends Mr. Durgom's speech . . . a speech that speaks eloquently for itself. ■

PIX

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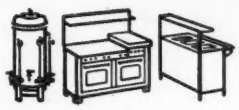
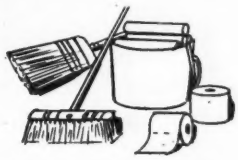


KITCHEN EQUIPMENT

KITCHEN UTENSILS



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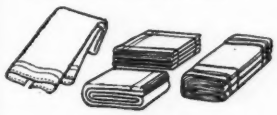

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x-ray special departments

Viral hepatitis: a hospital as well as clinical problem

by Kenneth B. Babcock, M.D., F.A.C.S. • Director, The Grace Hospital • Detroit, Michigan

Definition . . Viral hepatitis is loosely used to describe a closely related group of diseases caused by a filterable virus. In the literature appear such terms as post-vaccineal jaundice, serum jaundice, and transfusion jaundice tied together and called homologous serum hepatitis. Epidemic hepatitis, catarrhal jaundice and cholangitis are grouped together and usually called infectious hepatitis.

For hospital purposes and because the problem for all forms in a hospital is the same, they can be grouped into one term and can be called "viral hepatitis." The term is so used by many clinical writers.

History . . Forms of viral hepatitis have been recognized and described in medical literature for several hundred years and in the wars of the past century have played an important part. In World War II the disease reached epidemic proportion and over 170,000 cases were reported by the United States Army alone. It is again present in the Korean war. Civilian hospitals and outpatient departments are reporting an ever increasing number of cases.

Cause . . It is a well established fact that the causative agent is a filterable virus. The two most popular accepted concepts are that it is caused by contamination from human feces and by parenteral infection from infected blood, plasma and other parenteral solutions. It is common in children and young adults but has been reported at all ages and in both sexes. The virus is very hardy and is not killed by cold or freezing, nor by ordinary sterilization methods.

Transmission . . As far as civilian hospitals are concerned the majority of cases are undoubtedly caused by the parenteral introduction of the virus. The extensive use by hospitals in the past twenty years of parenteral medication plus possibly contaminated needles, syringes and stylets, must bear in our minds the brunt of the blame. All that is necessary is 0.01 milligram of infective serum. The large, seasonal epidemics are more a public health problem and contaminated water, food infected by human fecal fertilizer, flies, infected food handlers and utensils are blamed. Since the incubation period of the disease varies from three weeks to six months, a careful investigation and history is necessary to determine the source of the trouble and every step must be retraced to find the error.

Hospital cases and reports . . A hospital in Connecticut[1] reports four cases of hepatitis in diabetics who were given insulin from the same syringe although a fresh needle was used for each injection. Undoubtedly contaminated blood or serum was inadvertently drawn into the syringe while testing before injecting the insulin and infected insulin was then injected into successive recipients of the drug.

A London hospital[2] for luetics reported 68 per cent of the patients receiving arsenical therapy contracted jaundice. The multiple needle-single syringe method was used. Another hospital reported 50 per cent jaundice reduced to 5 per cent in the same type of case when the single syringe-single needle method was adopted with improved sterilization techniques.

Many clinical observers feel sure that the old "arsenotherapy jaundice" was really "syringe-transmitted jaundice." Experimental transfer to human volunteers has been demonstrated.

A military hospital[3] reported giving penicillin with 10cc syringes to infected orthopedic cases. Two cubic centimeters were given to each patient with a different needle but the same syringe used for five consecutive cases. Twenty per cent of the orthopedic cases acquired jaundice.

A Scandinavian diabetic clinic reported a high incidence of jaundice. Blood estimations were being performed and capillary blood obtained on finger puncture. The needle

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Inspect x-ray unit . . Left to right, Dr. Milton Berg, Bismarck, N.D.; Dr. Erik Poppe, Oslo, Norway; Dr. Tom B. Bond, Ft. Worth, Texas, and Dr. John S. Bouslog, Denver, president of Radiological Society of North America, inspect head x-ray unit at Chicago meeting

used was merely wiped off by ether swabs between patients. When the technique was revised and properly sterilized individual needles used, the jaundice disappeared.

One physician in Italy[4] was blamed by public health authorities for 112 cases of jaundice including 12 deaths. He was famous for giving intravenous "iron tonics." Investigation showed he was only averaging four minutes for boiling per syringe and needle . . not nearly enough to kill the virus.

A German observer noted that of 960 reported cases of jaundice over a period of 14 years in a certain area, 274 had been hospital cases during the year prior to the onset of their jaundice. He pointed out that, according to area population, the incidence of hepatitis was 40 times greater in prior hospital patients than in people who had not been hospitalized.

Another observer,[5] after reviewing many cases of viral hepatitis, claimed they should be called "hospital hepatitis."

Still another report tells of 16 cases among medical personnel in Memphis, Tennessee,[6] among four hospitals over a period of three years. The observation suggests the cause of accidental parenteral inoculation of infected blood through a wound in the skin as the mode of transmission. The authors even go so far as to call hepatitis a definite "occupational hazard" to hospital personnel handling these cases.

In our own hospital we feel very sure that two cases this past year of viral hepatitis could be traced to accidental inoculation. A surgical intern ticked his finger while closing a case of viral hepatitis in the O.R. which had not shown the classic findings until opened. He followed the text book course perfectly. The other case was that of a floor nurse who in removing an intravenous needle from a jaundice case got some of the patient's blood in a tiny abrasion on her hand.

In a very intensive review of the literature reporting these cases, viral jaundice has been traced to faulty technique in injecting the following substances not previously mentioned: bismuth, acriflavine, pentothal anesthesia, gold therapy in arthritis, typhoid vaccine in fever therapy, tetanus toxoid, therapeutic blood malaria induction, intracutaneous allergy tests and intracutaneous tuberculin tests.

In all the above named substances, it is to be noted the possibility of multiple injection by single syringe is present as the undoubted cause. There is no question but what the greatest hospital offender at the present time is the single syringe-multiple injection method by which infected serum or blood is regurgitated into the syringe and consequently inoculated into non-infected patients.

General comments . . It would appear obvious that any substance given intravenously, intramuscularly, subcutaneously or intracutaneously may become infective by contamination with the blood plasma or serum of an individual who harbors the virus of hepatitis.

In hospital practice, because of the wide use of blood and blood products, thousands of parenteral injections, the hazard of transmission is far greater than any other place. The strictest adherence to the rules of asepsis must be practiced by all hospital personnel.

There is no method of pre-sterilizing blood before using. Research with ultra-violet therapy and mustard gas has not proved efficient. It is a proven fact that blood plasma stored for six months at room temperature is sufficient to insure the death of the virus if present.

Specific recommendations

1. Use individual sterile syringes, needles or stylets for each injection or puncture.

2. In blood work, disposable needles and syringes should be used where practical.

3. For proper sterilization the following is recommended for syringes, needles, knives or stylets:

   A. Autoclaving — 125°C or 250°F for 30 minutes. (Preferred method)

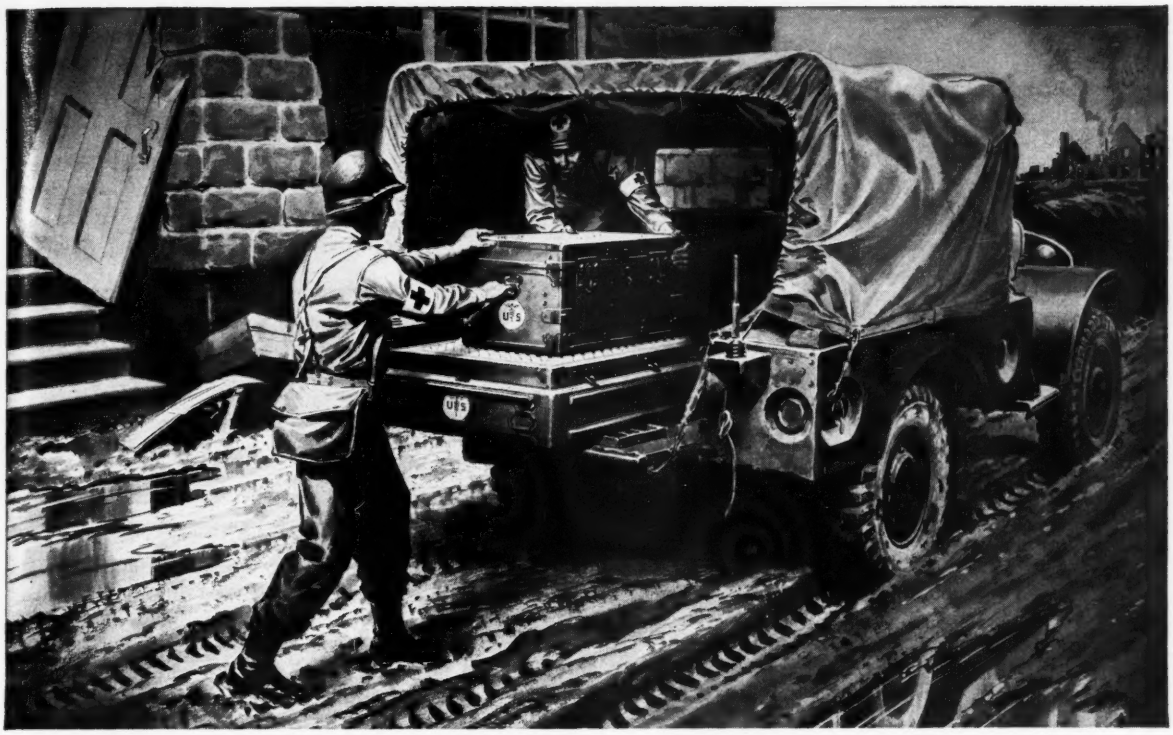
   B. Dry heat — 160°C or 320°F for one hour.

   C. Boiling — 30 minutes.

4. Non-refrigeration of pooled plasma and serum and storage of plasma at room temperature for six months.

5. Rejection of blood donors with a history of jaundice or fever of undetermined origin within the past two years.

6. Use of rubber gloves by laboratory technicians, nurses or at-



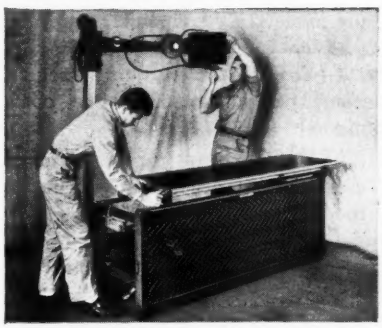
ARMED SERVICES ACCEPT PORTABLE FIELD X-RAY

New Picker Unit Operates Anywhere: Assembles in 5 Minutes

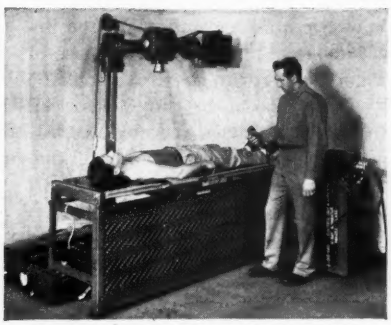
After months of rigorous proving tests, medical departments of all Armed Services have jointly accepted a new x-ray unit for operation in the field. Civil Defense authorities also see in its complete self-sufficiency an answer to the problem of providing x-ray facilities in disaster areas.

Like its forerunner, the U. S. Army Field X-Ray Unit of World War II, the new machine was designed and developed by the Picker X-Ray Corporation on its own initiative and at its own expense, with no development cost to the government. Quantity production is already well under way.

The unit is so portable and so self-sufficient that it can be used anywhere, even in forward areas. For transport it knocks down into two chests which are light enough to be moved by a medical team, compact enough to be carried in a jeep, or light truck, and rugged enough to be safely parachute-dropped. On arrival, the machine takes only five minutes to assemble for use in Mobile Field and Evacuation Hospitals. It will operate anywhere: on community power lines if available, or using a companion portable gasoline motor-generator. Picker X-Ray Corporation, 25 South Broadway, White Plains, New York.



FIVE MINUTES is all it takes to assemble the new Picker machine; no tools are needed. The lid of the long chest becomes the table front: other parts unfold into position or are attached in sequence. Packing members become operating parts.



HORIZONTAL RADIOGRAPHY and fluoroscopy are equally easy. The unit will operate continuously for fluoroscopy at 5 MA. and will withstand storage conditions from 50° below zero to 120° F. at humidity up to saturation.

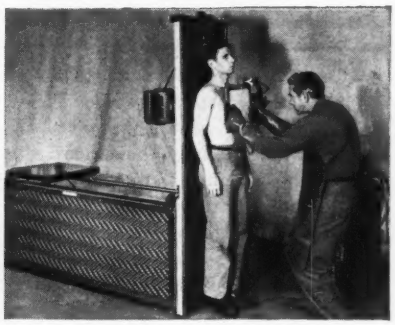


TABLE TOP SWINGS to vertical for fluoroscopy or radiography of upright patient. Sealed fluoroscopic screen is proof against warping or fungus invasion. Lead-rubber apron and gloves can be packed right into the same chest with the tubehead.

tendants when handling blood or excreta of jaundice patients.

7. Consult hospital pathologist on proper techniques.

Viral hepatitis must not mean "hospital hepatitis."

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Handy thing

continued from page 65

hospitals in the vicinity of each, starting with ambulances and carrying through to the operating room and the full nursing and auxiliary staffs, received wide notice and well earned praise.

As Sister Maria commented, atomic bombing may not be imminent but hospitals everywhere must be prepared for all sorts of community disaster, whether from fire or flood or from train or plane. Wherever these have occurred all over the country it is a fact, constituting the best possible tribute to the quality of the community hospital, that the desperately needed service of trained personnel and efficient equipment has been made immediately available. The typical and all but universal good-will enjoyed by hospitals everywhere has been enormously enhanced by this record as it will undoubtedly continue to be wherever the emergency arises.

Meanwhile the routine preparedness for whatever may come clearly enables the hospital to meet these local disasters with superb efficiency. It will also go very far toward readiness for the frightening specter of atomic bombing if that should ever have to be faced. The country's hospitals are definitely on the job and they may well be proud of the fashion in which they customarily meet every test no matter how severe. ■

Health projects

continued from page 60

aside program and no fixed limit on the demands of the military. The effort has been made to restrict the take of the armed forces in this category to not more than 40 per cent of the production but it is proving difficult to impose any such restriction. This situation may eventually play its part in forcing the setting up of some sort of priority rating although Washington authorities in general are trying to avoid this for a variety of reasons, including the still fresh recollection of the situation during World War II, when Triple A priorities became only hunting licenses.

Washington comment on the several presidential messages to Congress placed a good deal of stress on the evident abandonment, for the time being at least, of any attempt to push for any form of Federal compulsory health insurance. It was pointed out that the recent appointment of the new Federal health commission (HOSPITAL MANAGEMENT, January 1952, p. 76) was certain to mean the postponement for at least the current year of any further effort in that direction; and there has been some gleeful comment to the effect that it meant the shelving of FSA Administrator Ewing's consistent plugging for a Federal scheme. Since Mr. Ewing can hardly go counter to the national administration as a whole, the net result is evidently postponement, as indicated, whether or not that was the primary intention.

Ewing proposal . . It is possible, however, that legislation will be introduced later on for the purpose of implementing in some fashion the Ewing proposal to provide for all OASI beneficiaries and eligibles, including dependents, medical and hospital care at government expense, estimated at $200,000,000 a year or some such trifle. A casual suggestion was made and attributed to Mr. Ewing that this might be done by means of the existing Blue Cross and Blue Shield mechanism; but no plan for this has been worked out, and no such legislation has been proposed as would be necessary for this or any other aspect of the general plan.

To expand for hitherto unauthorized purposes any part of the vast trust fund of the Social Security system without explicit Congressional authority would of course not be possible and of course will not be done until the authority is granted. This at the moment does not seem at all likely despite the President's advocacy of higher OASI benefits and the admitted fact that the present benefits are very far indeed from constituting "social security." ■

How do YOUR x-ray costs compare with those on page ten ?

Pharmacy

continued from page 100

Chlorophyll ointment ..... $1.40 per gallon
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These eight items represent a large savings in one year. Imagine the saving possible when you manufacture 30 or 40 different items.

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4—Ease of compounding.

5—Provide better pharmaceutical service to the hospital.

6—And last but not least, add prestige to the pharmacy department. ■

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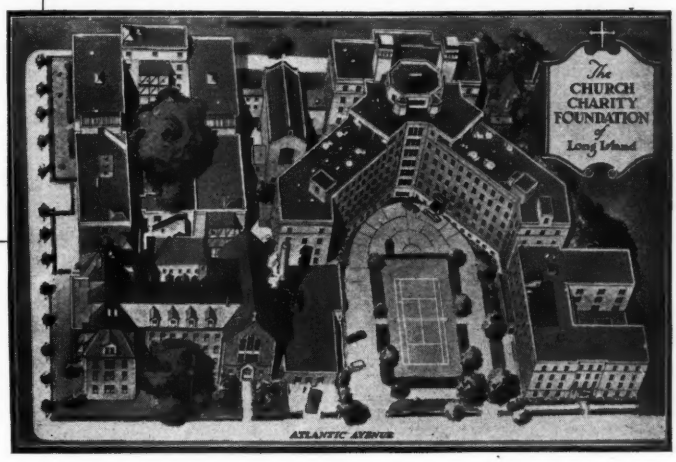

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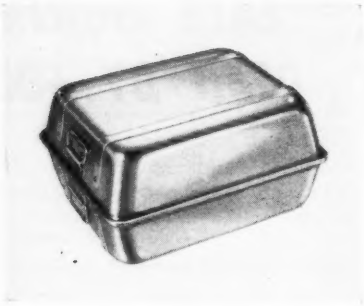

Utile gas-fired kettle

■ THE PERFECT ANSWER where quantities of food have to be prepared and steam is not readily available is the new Wear-Ever Aluminum gas-fired kettle, a product of the Aluminum Cooking Utensil Co. This new self-contained, sanitary kettle is said to save up to 50 per cent cooking time on meats with shrinkage held to a minimum. Wonderful for preparing meats, fresh fruits and vegetables, frozen foods, creamed dishes and sauces, soups, stews and pie fillings.

Circle 201 on mailing card for details.

Special diaper is designed

■ DESIGNED BY A NURSE, a new diaper introduces an easy and sanitary way to obtain urine specimens from infants. Made of non-irritating Vinyl, the diaper ties around baby and specimen collects in the special triangular reservoir. American Hospital Supply Corp., the supplier, explains that the diaper is removed, pointed tip is snipped off and the specimen drains into the collecting vessel. Neat, clean, easy and economical, the diaper is used once and discarded.

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Roasting pan self-bastes

■ TWO NEW FEATURES make Taste-Trough roasting pans, manufactured by Harlow C. Stahl Co., an outstanding addition to the Commercial Aluminum Chefware line. A built-in trough, which seals in the meat and flavor juices, provides a natural self-basting which produces the ultimate in savory and tasteful foods. Handles which stay close to the sides of the pan when not in use are another popular innovation in this smartly and practically styled roasting pan.

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How to brighten rooms

■ A NEW READY-TO-APPLY wall paint that will meet the rigid requirements of hospitals has been formulated by Sherwin-Williams Co. Fast-drying and guaranteed washable, "Quali-Kote" is available in sixteen up-to-date colors. Said to reduce both application and maintenance costs, the product has been tested under actual conditions within hospitals and been found to have excellent washability and resistance to dirt.

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Radio entertains patients

■ CORADIO, INC. is introducing its under-the-pillow type coin radio for use in hospitals and institutions. The speaker eliminates the noises and confusion caused by patient-owned loud speaker radios and each patient is given individual pillow speaker radio service which operates for 30 minutes for ten cents. A specially designed bed bracket attaches the easy-to-clean plastic unit containing the radio to the head of the bed.

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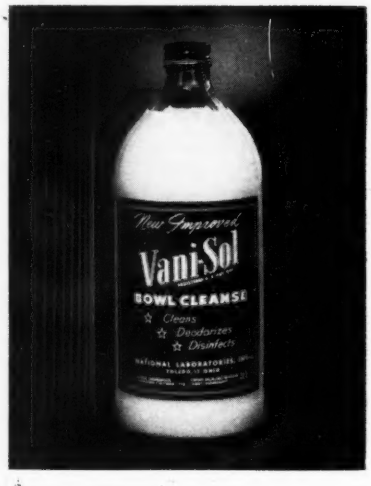

Housekeeping help

■ THE TRIPLE THREAT of Vani-Sol Bowl Cleanse is that it cleans, deodorizes and disinfects in one operation. This new, improved product of National Laboratories, Inc. is said to be a scientific combination of extremely effective chemicals made especially for the easy, quick removal of lime stain and organic deposits from toilet bowls. A real housekeeping help.

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Tape gives patient comfort

■ ADVANTAGES from the standpoint of patient comfort and reduction of irritation are claimed by Johnson & Johnson for Elastikon, a new type of adhesive tape. It is made from a uniformly woven cotton elastic backcloth, spread with a surgical adhesive mass. The adhesive surface keeps the tape in place with the desired support and pressure. It permits form-fitting bandaging.

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Detergent proves effective

■ DYNAKLEN is a superior new detergent for surgical and laboratory apparatus that is said to be particularly effective because it is refined. Each granule is small, yet contains no dust, so it dissolves with a minimum of stirring and leaves no residue. Safe, fast-acting and non-toxic, Dynaklen is particularly well adapted to laboratory glassware cleaning says Amer. Hosp. Supply.

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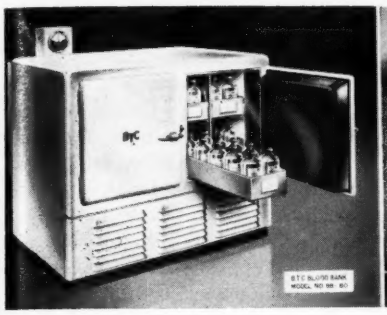

Blood bank has alarm

■ THE 1952 MODEL of Brewer-Titchener Corp's blood bank is equipped with a temperature indicator, has rigid temperature stability and an alarm system which will sound if temperatures vary from the controlled setting. With a capacity of 80 pint bottles of whole blood there is quick and easy access to contents by means of eight sliding pull-out trays equipped with automatic stops to prevent accidents. This arrangement enables the oldest blood to be selected first.

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These drapes are practical

■ ATTRACTIVE DRAPERIES of Fiberglas, which do not deteriorate under exposure to sunlight, are remarkably easy to maintain. They can be easily washed and hung wrinkle-free while damp. Made of glass yarns, they are translucent and admit a soft, diffused light and are permanently incombustible. The attractive pattern pictured here is Kashan. Owens-Corning Fiberglas Corp. makes the wonderful draperies that would be a practical and pretty addition in your hospital.

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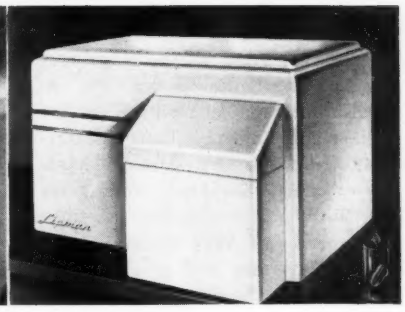
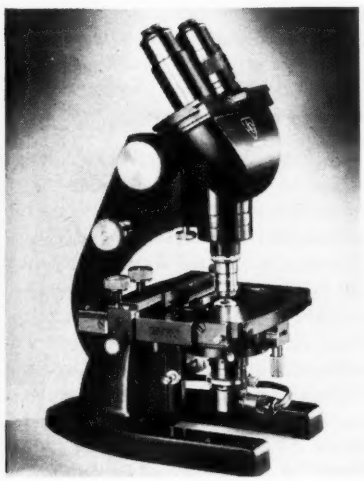


Junior ice maker

■ SMALLEST AUTOMATIC ICE MAKER on the market . . . and priced accordingly . . . is the Junior "Ice Boy," a new counter model ice tip machine by Lipman Refrigeration, division of Yates-American. This compact, handsomely styled unit produces ice tips of any desired size, over 100 pounds a day. Completely automatic, the unit stops operation when storage of ice is at capacity of 1.5 bushels and starts again when the supply of ice is partially expended.

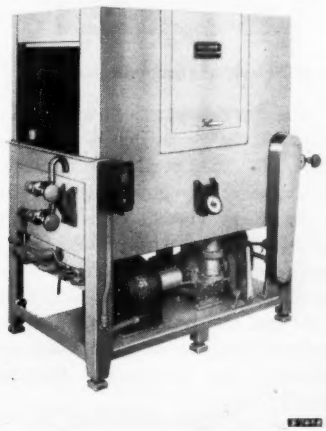
Circle 211 on mailing card for details.



Latest microscope

■ A NEW DARK FIELD microscope, pictured above, combining the latest AO Spencer mechanical features with an improved illuminating system is announced by American Optical Co. "Pinch-grip" mechanical stage permits interchange of slides without disturbing stage settings. Focusing is smoother and easier; wear is reduced and backlash eliminated.

Circle 212 on mailing card for details.



More efficient dishwasher

■ A SINGLE-TANK dishwashing machine with two-compartment construction which combines the advantages of automatic conveyor operation with the compactness and economy of a single-tank machine has been added to Toledo Scale Co.'s line of dishwashers. Designed for rapid, easy cleaning, its rigid construction with all parts held in firm alignment assures quiet operation.

Circle 213 on mailing card for details.

Milk service is metered

■ OPERATION is exceptionally easy with Norris Dispensers, Inc.'s new fluid milk dispenser that serves milk in measured amounts. Just set the dial, place glass or cup in position and press a button. The dispenser will handle glasses, paper cups or any other type of container. Milk remains in a sealed, sterile can until served so that complete sanitation is maintained at all times.

Circle 214 on mailing card for details.

Dry or moist heat for food?

■ THE TWO SIDES to the important question of whether to use "dry" or "moist" heat for hot food storage are both right, says Southern Equipment Co. The Seco-Matic electric dry-or-moist hot food table gives you both, and conversion to either is a rapid and very simple procedure. This unit will give you the type of heat best suited for each food, and is a kitchen convenience well worth looking into.

Circle 215 on mailing card for details.

Corner cutter for film

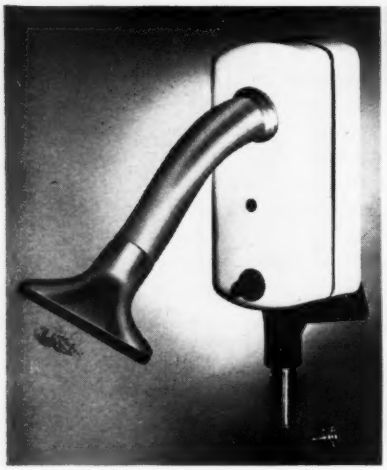
■ SCRATCHING OF FILMS and other damage caused by sharp and jagged corners of film are eliminated by a new cast metal, hand-operated x-ray film corner cutter announced by Picker X-Ray Corp. The transparent guard provides protections against the cutting edge as well as visualization of the position of the film being cut. Guides along the edges of the cutter facilitate placing the film in the cutting position.

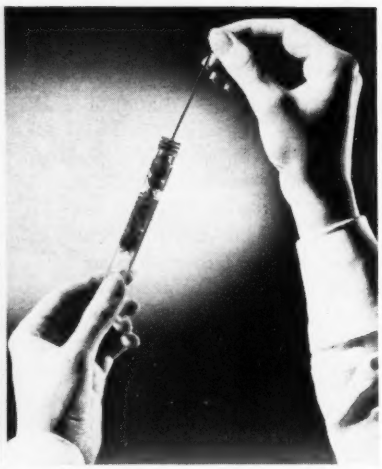
Circle 216 on mailing card for details.

Bone decalcifying simplified

■ A NEW PREPARATION that will afford hospital pathologists a superior bone decalcifying technique for study of tissues is now available from Winthrop-Stearns, Inc. The product, Win 3000, is an ion exchange resin with advantages which include better preservation of cellular details of tissues and more rapid completion of process and elimination of daily changing of solutions.

Circle 217 on mailing card for details.





3 new tubestand features

■ RADIOLOGISTS and x-ray technicians will be interested in three unusual features of the new ceiling-floor x-ray tubestand by Westinghouse. All motions and electric locks are controlled directly in front of the operator. It has the widest range of tubehead travel and the tubehead can be angulated 135° to handle the most advanced radiographic techniques. Chrome finished floor rail has a rounded surface and is easy to keep clean.

Circle 218 on mailing card for details.

Dryer has hospital uses

■ FOR QUICK SETTING and drying of plaster casts, Electric-Aire Engineering Corp. has engineered a new, portable electric drying unit. One dryer will dry the largest casts . . . affording comfort to the patient and saving much time for hospital personnel. Easily portable, the dryer has many other applications including bedside hair dryer, for warming patients in shock and for bed-warming.

Circle 219 on mailing card for details.

Tiny brush cleans tubes

■ THIS TINY BRUSH was specifically designed for cleaning constriction tubes. It slides easily through narrow tube openings and thoroughly scrubs every crevice of short, long and double-end tubes. A special fan tip assures complete cleansing of round tube ends. Over-all length is six and one-half inches. This ingenious little brush is offered exclusively by American Hospital Supply Corp.

Circle 220 on mailing card for details.

How to conquer dirt

■ ALMOST INSTANT EMULSIFICATION of gummy soil and embedded dirt by simply wiping on and wiping off a low-cost solution of Wall-Kleen Krystals is claimed by Ross & Story Products Corp. A non-abrasive, soluble product in crystal form, Wall-Kleen is recommended for cleaning all types of painted, varnished and metal surfaces, as well as wood, linoleum, concrete and other types of floors and tile.

Circle 221 on mailing card for details.

Prolonged pain prevention

■ A SINGLE INJECTION of Efocaine provides six to twelve days' anesthesia, according to E. Fougera & Co., which recently developed this amazing, new, long-acting local anesthetic. This unique, prolonged prevention of pain promises to open a new era in local anesthesia and analgesia and has been shown to be especially valuable for postoperative use in minor surgery.

Circle 222 on mailing card for details.

New probe is lightweight

■ A NEW, LIGHTWEIGHT radiation probe, for detecting and measuring alpha, beta, gamma and neutron radiations, has been announced by General Electric's special products division. The 10-pound probe is made for use in hospitals and will have application in monitoring contamination of clothing, personnel, laboratory equipment and facilities even under difficult circumstances.

Circle 223 on mailing card for details.

New asthma treatment

■ TWENTY-FOUR HOUR protection of the asthmatic patient without side-effects is said to be provided by Irwin, Neisler & Co.'s new Dainite tablets. The tablets are packaged in unique units containing 48 day tablets and 18 nite tablets. Use of antinausea factors permits more effective, prolonged dosage of aminophylline than previously available in preparations for asthma treatment.

Circle 224 on mailing card for details.

names & news of suppliers

hm

Painting . . of the original Queen of Angels Hospital, Los Angeles, long since outgrown, is presented to Sister Mary Raymond, superintendent, by H. M. Bilden of Ciba Pharmaceutical Products. Looking on are Sister Mary Junilla, chief pharmacist of the hospital, and G. A. Jundt of Ciba. Hospital grew from 15 to 502 beds since 1925.

Employes donate blood at Lilly processing unit

■ BLOOD DONATED by Lilly employes is the first being processed by the new plant operated by Eli Lilly & Co. in Indianapolis for the production of dried human blood plasma. This plant, operated for the federal government, is housed in a five-story structure, the interior of which resembles an up-to-date hospital.

An American Red Cross "bloodmobile" unit is visiting the two Indianapolis plants of Lilly in order to receive the initial donations from workers. The blood collected is brought directly to the new unit for processing.

Seamless Rubber appoints Chicago sales representative

■ SEAMLESS RUBBER CO. has announced appointment of Gilbert Frommelt as sales representative in the Chicago area. Mr. Frommelt will make his headquarters in the company's Chicago office, 53 W. Jackson Blvd.

Mr. Frommelt brings to Seamless a wide acquaintance among hospital and surgical supply dealers and hospital administrators. He has recently severed his connection with Davis & Geck, with whom he was affiliated for the past four years.

Parke, Davis builds modern drug laboratory

■ AN ULTRA-MODERN new laboratory, specifically designed to handle special problems of new drug development, has just been completed in Detroit by Parke, Davis & Co. Another step in the company's broad expansion program, the new laboratory will house the greater part of the Products Development Department. It becomes one of the more than fifty buildings which constitute the Parke, Davis home offices and labs on a 27-acre site on the north bank of the Detroit River.

Rice named hospital head at Wilmot Castle

■ WILMOT CASTLE CO. announced recently the appointment of Frank L. Rice as manager of its Hospital Department, succeeding Norman S. Robson, who retired as of Jan. 1, after holding this important executive position for the past twenty-five years.

Mr. Rice became affiliated with the company in 1936 and has served as Mr. Robson's assistant for some years. His broad experience in hospital planning . . which includes facilities for surgical sterilizers and lights, central supply, milk formula laboratories, and allied hospital services . . qualifies him as a competent authority in this field.

Other news . . To fill two newly created executive vice-president positions, Upjohn Co., Kalamazoo, Mich., has promoted E. G. Upjohn, M.D., formerly vice-president and medical director, and C. V. Patterson, formerly vice-president and director of production.

E & J Manufacturing Co., hospital equipment manufacturer, has moved to new and enlarged factory and office facilities at 100 E. Graham Place, Burbank, Cal.

Dale Scholz, M.D., has joined the medical consultant service of Armour Laboratories, Chicago, as regional medical director in the New York area.

New assistant to the medical director of Schenley Laboratories, Inc. is J. Campbell Howard, Jr., M.D. Announcement of Dr. Howard's appointment was made by Dr. Charles E. Dutchess, vice-president and medical director.

American Machine & Foundry Co. has announced the naming of J. J. Cranmore as sales manager of the Lowerator Department of the company's General Products Division.

Fifteen schools of pharmacy from various universities throughout the country will be guests of Abbott Laboratories during the first half of 1952. Typical programs include dinners, sight-seeing trips, theater parties, tours of the plant and talks by Abbott officials.

Dr. Harry J. Weiner has been named associate medical director of Winthrop-Stearns Inc. ■

housekeeping·laundry·maintenance

Job analysis, time-motion study applied to housekeeping

by **Gustav A. Killenberg, C.P.A.** . . Partner of Harris, Kerr, Forster & Company

■ THERE IS NOTHING NEW in the fundamental principles of "job analysis" and "time and motion study." In fact, ever since one man has been charged with the duty of supervising the work performance of another, the underlying principles have been used as a tool of management. Consequently, each housekeeper in her daily tasks, whether she labels these mental processes or not, has used some if not all of the techniques. This has been done automatically. She would not be an efficient housekeeper and would not be approaching her job as expected by management if some of the considerations inherent in these two titles were not brought to bear in the course of her executive direction.

We, therefore, might well ask ourselves What do these two titles mean? What do they encompass? "job analysis" means just that . . an analysis of the job. "Time and motion study," too, means just what it says . . a study of the time and motions necessary to do the job. Both point to an economy of motion, to putting things in their right place, and to avoidance of unnecessary labor on the part of the employe.

It is important to note that the basic concept of both of these techniques does not entail "speed-up" of labor; their objective is to get more productivity from the labor expended. Such productivity must come from more efficient management with the sole idea of making the job easier for the employe and at the same time obtaining a full and efficient day's work for the money expended. Labor generally, and this is particularly true in production plants, has begun to recognize that the analyst is a friend who is seeking to show them easier ways of doing a particular job . . not a demon who would wring out the last ounce of blood and perspiration.

When we look at the housekeeping problem in a hospital, it is at first difficult to see how industrial production techniques can be readily applied, but fuller consideration shows that the basic truths are in no way inapplicable, even though the application may involve a variation of technique.

Job analysis . . First I would like to deal particularly with "job analysis." Probably the quickest way to convey some thoughts to you is to give you my idea of an application of the techniques to the housekeeping problem in hospitals.

"Job analysis," insofar as hospital housekeeping is concerned, can be performed in four distinct steps, as follows:

1. An analysis of the type work to be done, such as floor polishing, floor cleaning, high dusting, carpet cleaning, painting (if that comes under your direction), sweeping, bed making and the like.

2. An analysis, or breakdown, of the entire housekeeping job by areas.

3. An analysis of the duties of each class of employe.

4. An analysis of the duties of each employe.

After these analyses have been made and recorded, it will be seen that the entire housekeeping problem has been broken into its component parts readily adapatable to further study. Let us now look at the individual types of analysis in greater detail.

1. Types of work done. In this analysis the first step would be to list in logical sequence all of the different detailed operations performed by the staff under the housekeeper's direction. As part of this analysis the executive housekeeper or analyst should set forth work standards insofar as the *quality** of work is concerned and the

A paper read at the AHA Institute on Hospital Housekeeping at Webster Hall, Pittsburgh, June 1951.

*Much study has been done on work quality standards and the American Hospital Association and the American Hotel Association have in their reference libraries many studies setting forth work standards generally accepted as norms. These of course will differ in each locality and with each hospital and depend to a large degree on the administrators' or directors' policies. We find here a very definite proof that job analysis, although not an exact science, is a science that carries with it a great amount of professional and informed judgment.

Thus, in work quality standards, while it will be found that asphalt tile should be polished with a non-rubbing wax rather than a buffed wax, by the same token the frequency of the operation will vary, depending upon the traffic in a given area, the administrative insistence upon appearance, and even the age of the surface to be polished. Thus, in setting up the tentative specifications for the manner in which certain jobs are to be done and the frequency of the operation, the judgment of the housekeeper, informed by available data and statistics, is all-important.

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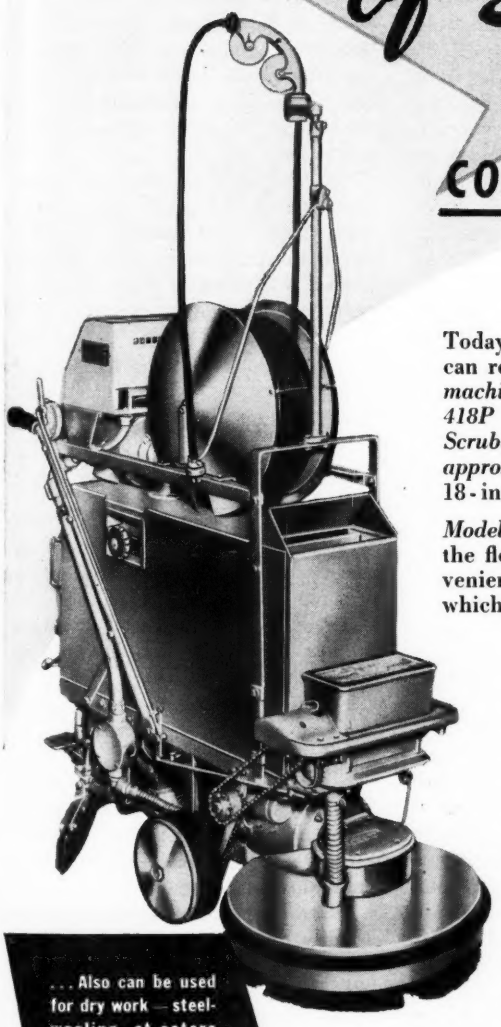

...Also can be used for dry work — steel-wooling, et cetera

Today, even buildings with but 2,000 to 15,000 sq. ft. of floor space can reap the labor-saving, cost-reducing benefits of *combination-machine-scrubbing.* Here's a *Combination Scrubber-Vac, Model 418P* at left, that's specially designed for such buildings. This *Scrubber-Vac,* which has an 18-inch brush ring, cleans floors in *approximately one-third the time* required with a conventional 18-inch machine and separate vac unit.

Model 418P applies the cleanser, scrubs, and picks up (damp-dries the floor) — *all in one operation!* Maintenance men like the convenience of working with this single unit... the thoroughness with which it cleans... and the features that make the machine simple to operate. It's *self-propelled,* and has a *positive* clutch. There are no switches to set for *fast* or *slow*—slight pressure of the hand on clutch lever adjusts speed to desired rate. The powerful vac performs efficiently and quietly. (Powder dispenser is optional.) Compactly built, the *418P* also serves advantageously in larger buildings for the care of floors in narrow aisles and congested areas.

Finnell makes *Scrubber-Vac Machines* for small, vast, and intermediate operations, and in *self-powered* as well as *electric* models. From this complete line, you can choose the size and model that's exactly right for *your* job (no need to *over-buy* or *under-buy*). It's also good to know that you can lease or purchase a *Scrubber-Vac,* and that *there's a Finnell man nearby* to help train your maintenance operators in the proper use of the machine and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest *Finnell Branch* or Finnell System, Inc., 2702 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

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frequency of performing certain procedures.

2. An analysis of the entire housekeeping job by areas. Let us list the various types of areas. This is done by making a list of all the areas which are to receive the housekeeping department's ministrations. Let us list the reception hall, the patients' rooms, corridors, laboratories, nurses' residence, doctors' offices, clinics, administrative offices, etc. If these areas are divided among assistant housekeepers, let us build our schedule to divide the area study by these assistants.

Work categories . . The next step in the analysis is probably the most burdensome, requiring much time and thought. This step is a detailed listing of the work done in each area both by type and frequency. In listing the results of this study, each area should be named and then immediately following the housekeeping duties to be performed every day, every other day, periodically, and so on in the various periodical intervals. Also, it should be broken down as between the duties to be performed either by day or by night.

Let me say at this juncture that I fully understand the difficulties involved in maintaining a rigid schedule. It just can't be done. It is quite evident that the doctors will not discharge their patients in accordance with a strict housekeeping schedule and thus permit the maids, orderlies and housemen to perform the necessary major cleaning of patients' rooms at exactly stated intervals. It is here that judgment again enters the picture. If it has been determined that a room on the maternity floor shall be completely stripped and thoroughly disinfected at least once in every 20 days, then the assistance of the admitting desk must be obtained to give the housekeeper sufficient time to perform these functions through the judicious scheduling of room occupancies.*

Thus far, we have analyzed the job to be done but have given no attention as to which employes are to do this job. Therefore, a third analysis should be made.

3. An analysis of the duties of each class or type of employe. In this study, the initial step would be to take our first analysis sheets on which are recorded the work standards and the types of work to be done and indicate thereon whether a man or a woman can most efficiently and economically do each particular job. Then let us review the list again and indicate whether they shall be porters, maids, window washers, orderlies, assistant housekeepers, etc.

With this information at hand we are now able to indicate on the area study the type or class of employe who can most effectively and economically do the work. After applying general norms which have been accepted by common usage, it is important that each job be studied in detail since varying conditions in a particular hospital might indicate that the normal conception of distribution of duties is not the most efficient or economical.

For example, while we normally consider that vacuum work is the job of a houseman, it might very well be that, in considering small areas and the light type cleaners presently on the market, it will be found that a maid would more efficiently do this.

Final step . . There remains one last step: to assign specific duties to specific employe units.

4. An analysis of the duties of each employe. At this stage of the study, before going into the "time and motion" field, the judgment of the housekeeper is all-important as to the amount of work that can be accomplished by any one employe in any given period. This judgment applied to the analyses thus far developed can be used to determine the number of work hours of each type of employe required in each area and, as a result of that, the number of employes required to do the whole job. It will be interesting to compare these totals with the payroll experience at the time the "job analysis" project was begun.

Stemming out of this would come work schedules which would give in detail the duties of each employe for every day of the week. This might be done by having a work schedule for each employe in which the days of the week would be named across the top of the card and the specific duties of that employe listed at the left hand side. By blocking off the days and duties with lines, there could be indicated in each square the frequency of the job to be done. For instance, in a solarium it might show that high dusting, low dusting and dusting of all furniture and lamps should be done every night; dust mop floor every night; vacuum draperies and upholstery once weekly; polish wood furniture once weekly; wax and polish floor every other week; wash light ceiling fixtures once a month, etc.

The "job analysis" has now been completed. The entire housekeeping job has been analyzed and the varying duties recorded. The housekeeper will probably find many superfluous procedures and practices have been added to the list where they have long since been accepted as necessary adjuncts to the housekeeping job without too much consideration as to the why's and wherefore's.

A word of warning: constantly check and recheck your analyses with current procedure. Refuse to accept wide deviations without a rational answer.

As a result of an analysis such as has been suggested, it will be found that:

First . . the housekeeper has a detailed record of the entire housekeeping problem.

Second . . the entire problem has now been divided into smaller units in logical order and sequence where each can receive orderly and individual attention.

Third . . work standards as to quality have been recorded in such a manner that the information can be distributed to the appropriate employes and thus reduce the effect of individual abilities and performance on the standards of cleanliness.

Fourth . . the work has been divided among the types of employes on the basis of the most efficient and economical concepts.

Fifth . . duplication of duties has been eliminated.

*In practice, this is a difficult problem but the fact that the norm has been set is the first step in approaching the solution. That a work schedule such as suggested is entirely feasible is evidenced by the fact that the housekeeper in the Greenbrier Hotel worked out just such a schedule as I have been mentioning and if you are interested in reviewing it you will find it published in the *Hotel World-Review* of Sept. 16, 1950.

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provides ample light, air and vision

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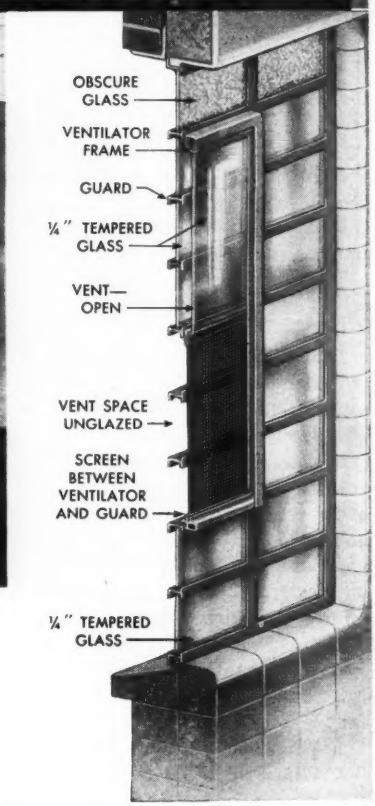

The scientifically planned and designed window for hospitals dedicated to rehabilitating the mentally ill

Authorities governing mental hospitals have long questioned the established practice of using windows with ventilators that swing into the room, or windows with the old-style heavy guard protection separate from the window. Special concern is with windows in corridors, hospital wards, offices, or any other location where they create an injury hazard to patients and staff members; or where sight of bars separate from the window is aggravating to the patient.

Bayley engineers, backed by 20 years' specialized experience in design and manufacture of institutional windows, have now developed the SAF-T-GARD WINDOW with a *vertically* sliding, screened, super-imposed ventilator assembly that overcomes these hazards. Not only does the SAF-T-GARD meet this demand of mental hospital authorities, but also it retains all the highly prized features of the widely used "Bayley Guard-Window-System." These, coupled with many additional improvements in this new window, assure maximum light, air, and vision, with extra safety, detention-free appearance, and low-cost maintenance.

Due to design considerations, close cooperation between architects and Bayley engineers is essential throughout all planning stages in applications of the SAF-T-GARD WINDOW. Write today for details.

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Sixth . . work schedules have been established.

Some readers may feel that a "job analysis" procedure such as I have set forth is too complex for his or her organization. Whether one approaches it in the detailed manner suggested or analyzes the problem in a different manner is of relative unimportance. The principal point to be remembered is that "job analysis" is not a mysterious, highly technical procedure but one which every executive must approach in one form or another and if some of the techniques developed by industry can be of assistance to us in our problems, we would be foolish not to avail ourselves of the thinking and studies that have been applied to this subject.

The active, analytical, inquiring mind is the key to the solution.

Time and Motion Study

The subjects "job analysis" and "time and motion study" are really interdependent and can never be completely separated.

Previously, we briefly defined "time and motion study" as a study of the time and motions necessary to do the job. To expand this further, we find that "motion study" begins with taking the job apart motion by motion and studying each operation in light of certain questions:

1. Why is this detail necessary?
2. What is the purpose of the detail?
3. Where should it be done?
4. When should it be done?
5. Who is best qualified to do it?
6. And finally, how can it best be done?

The "time study" begins with a record of the time it takes to make each motion and is basically the measure of the parts of the breakdown. "Time study" is one of the measures by which we are able to judge whether an improvement has been made as a result of our "motion study."

We see then that the first requirement of any "time and motion study" is to break down the job into as many separate functions as practicable and to apply concentrated thinking to the motions and time required to perform each part of the job. It was with this in mind that we considered in such detail the processes of "job analysis"; the approach previously outlined is a good start for the second phase of the job.

At this point, however, let me give a word of caution. Judgment must be applied in determining how small the pieces to be studied are to be. In some cases the process to be studied as a unit can be broken down into rather minute details. For instance, the folding of linen might be studied in units as small as the motion of one hand in making one fold, whereas in the cleaning of a room it might be impractical to make the breakdown so fine that an attempt is being made to determine how long it takes to dust one particular piece of furniture. If the "job analysis" has been made with care, the unit breakdown for "time and motion study" application will be over half done.

PROCESS CHART (Otis type) . . Washing and waxing corridor 4 South

TRAVEL IN FEET	TIME IN MINUTES	SYMBOL	DESCRIPTION
50	1.00	O T I S	Walk to scrub closet, obtain mop, pail, detergents, etc.
	1.25	O T I S	Fill two section scrub pail.
90	.50	O T I S	Move supplies to area to be processed.
	18.00	O T I S	Mop floor.
90	.60	O T I S	Return supplies to scrub closet.
20	.30	O T I S	Obtain wax supplies and waxer.
70	.40	O T I S	Return to area to be processed.
	15.00	O T I S	Wait for floor to dry.
	22.00	O T I S	Apply wax and buff.
	1.50	O T I S	Inspect waxed surface.
70	.45	O T I S	Return waxing supplies.
390 Ft.	61.00 Min.	3-6-1-1	Totals
	41.25	O 3	Summary
	3.25	T 6	
	1.50	I 1	
	15.00	S 1	

PROCESS CHART (Using symbol method) . . Washing and waxing corridor 4 South

TRAVEL IN FEET	TIME IN MINUTES	SYMBOL	DESCRIPTION
50	1.00		Walk to scrub closet, obtain mop, pail, detergents, etc.
	1.25		Fill two section scrub pail.
90	.50		Move supplies to area to be processed.
	18.00		Mop floor.
90	.60		Return supplies to scrub closet.
20	.30		Obtain wax supplies and waxer from different closet.
70	.40		Return to area to be processed.
	15.00		Wait for floor to dry.
	22.00		Apply wax and buff.
	1.50		Inspect waxed surface.
70	.45		Return waxing supplies.
	41.25	○ - 3	
	3.25	o - 6	Summary
	15.00	▽ - 1	
	1.50	□ - 1	
390 Ft.	61.00 Min.	11	Totals

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Industry, and more particularly industrial engineers, studying "time and motion" problems, have developed over the years certain tools. It may be well for a moment, before proceeding further, to become acquainted with these.

The first, and to my mind the most important, is an analytical, inquisitive and informed mind. With this single tool, "time and motion studies" can be made. Without it, all other tools become worthless.

The second of these tools, and very important, is the "Ten Principles of Motion Economy." These principles, sometimes called the "Ten Commandments of Time and Motion Study," are stated in varying words by different engineers. At first it may seem that they have little bearing on housekeeping duties but, on further reflection, it will be found that each of them can be applied in one degree or another to the problems at hand. These principles are summarized as follows:

1. The motions of the two hands of the worker should be both simultaneous and symmetrical wherever possible.

2. Tools and materials to be used by the worker should be located close to and preferably in front of the worker and all motions, particularly transportation, should be restricted as much as possible.

3. There should be a definite and fixed place for all implements, tools and supplies necessary for the worker to perform the job.

4. Gravity feed bins and containers should be used to deliver materials close to the point of use.

5. Tools and materials should be pre-positioned whenever possible; they should be stored between operations in such a manner that they are grasped in the position they are to be used.

6. Drop deliveries should be used wherever possible.

7. Hands should be relieved of all work that can be done with equal or greater advantage by the feet. Power operated tools and equipment should be used where equally economical.

8. Materials and tools should be located to permit the best sequence of motion. Rhythm is an essential element in an easy work pattern.

9. Smooth, continuous motions of the hands, legs or body are preferable to zig-zag motions or straight line motions involving sudden and sharp changes in direction.

10. The worker should be made as comfortable as possible. On any bench or table work, the tables and chairs should be so arranged as to permit the operator to work alternately in a standing and sitting position. Adequate lighting and ideal facilities enhance production in that they reduce fatigue.

Charts . . The third group of tools are the various charts used to record time and motion studies. The first of these is a process chart on which is recorded in sequence the various motions required by an operation. Such process chart would have as headings: The travel in feet, the

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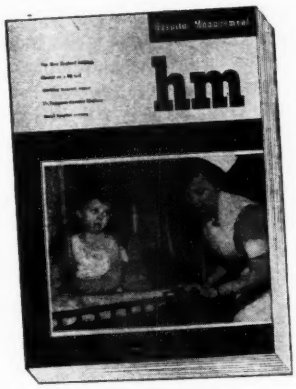

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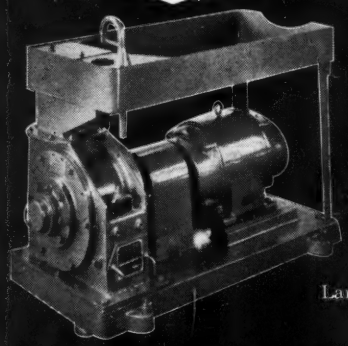

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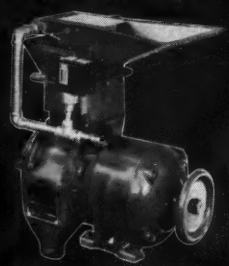

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time required, symbol of operation, and finally a brief description of the operation. For ease in preparing such a chart, many different types of symbols have been used, depending to a large degree upon the performance to be analyzed. One of these uses the following symbols:

O — An operation
o — Transportation or movement
▽ — Storage or delay
□ — Inspection

Another known as the Otis System makes use of symbols as follows:

O — Operation
T — Transportation or movement
I — Inspection
S — Storage or delay

On page 130 are illustrations of process charts for recording the sequence of motion involved in the washing and waxing of an unobstructed floor. It should be noted that these, as well as all other examples used, do not represent actual experience but certain component parts have been magnified to more clearly illustrate a point.

Another frequently used chart is the Simo chart which takes its name from the words, Simultaneous Motion, and records the process or operation performed by the right and left hands in such a way that the analyzer can compare the motions of the two hands in any given operation. If the housekeeper's duties encompass the direction of the laundry and linen room, the application of such chart will be helpful in analyzing many of the processes performed in these two places.

Aside from these two charts there are many others, such as map charts, man and machine charts, etc. A map chart is used where the process entails movement of considerable distances such as the cleaning of a large room or a corridor, transporting linen to linen closets, etc. Man and machine charts are used to record simultaneously the time and motions of a man and the machine he is operating. Briefly, the main objective in all of these charts is to record in a systematic manner the motions and time elements involved in a given process.

The fourth group of tools is probably the most obvious. It comprises the stopwatch, measuring tape, ruler, etc. Of these, the only one that may require special comment is the stopwatch, which for this purpose usually has a large sweep hand, making one complete turn every minute, on a dial graduated into 100 parts. An additional and smaller dial contains a hand which records the full minutes elapsed since the watch was started. This watch can be started and stopped at will and returned to a zero starting position very easily. By using a watch such as this, the engineer has all of his time factors recorded in a decimal system for greater ease in combining or dividing his time findings.

We have set forth some of the principles and named the tools of the "Time and Motion" engineer. At this juncture it would be well to delve into their uses. After selecting the smallest practical unit for test, the first thing to do would be to make a process chart. Let us as-

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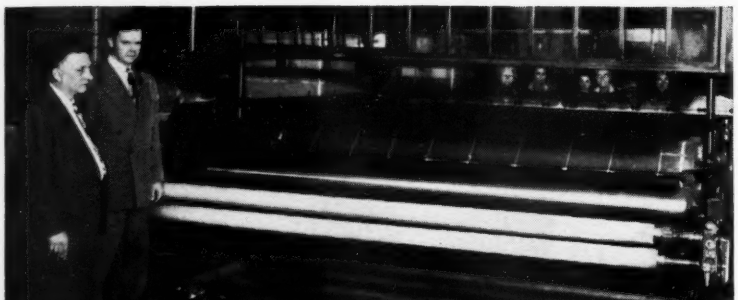

Joseph H. Hill (left), Laundry Manager, and Tom O'Connor, REVOLITE *Representative, check* REVOLITE *installation at Allegheny General Hospital, Pittsburgh, Pa.*

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sume for a moment that the unit to be studied is the cleaning of a venetian blind. The present sequence of motions from the time the employe leaves the immediately preceding duty should be charted up to the point where the next duty is begun. This would take in the walking to the supply source for the duster, positioning of the blind, the dusting itself, adjusting the blind to its former height, returning the duster to its original location, and finally walking to the next duty.

After the charting, each motion should be timed. (A right and left hand, or Simo chart, would probably be unnecessary and impractical in this operation.)

Analyzing results . . Now apply to the chart the thinking and judgment of the analyst asking the questions originally set forth of: Why? What purpose? Where? When? Who? and How? It may be found that the present method is to use a forked brush and clean the venetian blind with the slats in a horizontal position. Then it might be thought better to turn all the slats one way and dust the blind and then turn them the other way and complete the dusting.

The time element under the new process would then be recorded and I believe you will find that the quicker job is done by placing the slats in as near a vertical position as possible and broadly dusting the blind. It will be found, however, that this dusting is not as thorough as the forked brush dusting and consequently, will require a more frequent major cleaning and renovation. Therefore, to complete the study, the housekeeper must either use his or her judgment as to the relative advantages of one method over the other, or if mathematical exactitude is desired, a further "time and motion study" should be made of the major cleaning or renovation job. The costs calculated for this major process must then be combined with the dusting costs established to evaluate the total time and materials required in the longest cycle.

We have not as yet considered the motions necessary to obtain the duster and return it to its storage position. If our thinking applies the rules that tools should be pre-positioned in as convenient a place as possible, then the distance traveled and the time required may be considerably cut down by means of mechanical contrivances such as a maid's cart where all the tools necessary to do the job in one place would be at hand in that place. Further, the duster should be so placed on the cart that when grasped in removal, it is in the hand in a position ready for immediate, convenient use.

As can be seen from the foregoing example, applied judgment is the key to unlocking the benefits of "time and motion studies." The mere recording of time and motion as such, while it yields certain statistical information, does not in the final analysis perform any process more economically. Also seen in the foregoing example is the fact that "time and motion studies" cannot stand alone but must be combined

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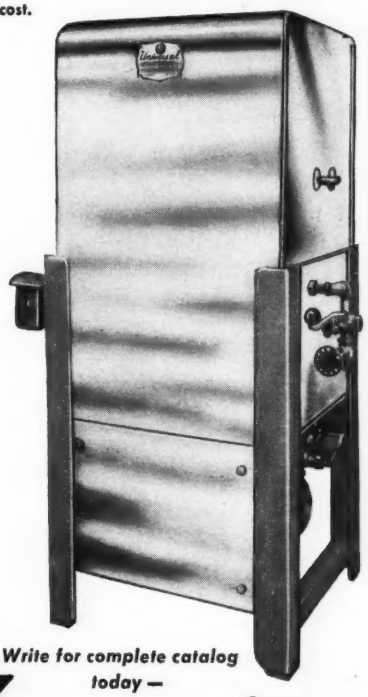

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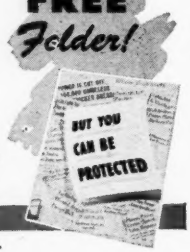

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with all the elements that are involved in the total cost of an operation.

Let us take another example. Granting that the use of proper detergents will do an adequate job of wall washing, let us assume that we have eliminated all waste motions and that we have provided the proper equipment at the proper place at the proper time. The process is timed under certain conditions and it is found that at a washing frequency of once every two months, the time is one-half that required if the frequency is on a four-month basis.

From the facts that we have thus far developed, it would appear to be more desirable to wash the walls in this particular area every two months since it would cost no more in labor and it might be considered that the additional cost of the detergents was a small price to pay for the improved appearance. Yet an examination of the problem would show that the painting frequency under a two-month wash schedule might be two-thirds that of a four-month wash schedule. Therefore, in order to arrive at a true study and correctly evaluate the comparative advantages of the two methods, the painting cost must be taken into account and the final costs compared as well as appearance and cleanliness.

One or two more items should be mentioned. In timing any operation, a general rule is to record the time, taken under normal conditions, at least ten times in order to arrive at a workable norm. Also, the timing should not be made on the basis of any one worker. Three or four different employes should be timed in each operation and the estimated efficiency of each worker evaluated and expressed in percentages. The time of each worker is then reduced to that of a 100% efficient worker, and by averaging time of all the workers, a maximum efficiency standard is arrived at. The standard then should be lowered to allow for fatigue, abnormal conditions, personal comforts and delays, to arrive at a work time, or production, standard. This is called the "process of levelling."

continued on page 139